DOCUMENT RESUME

ED 170 971 EC 114 676

AUTHOR	Peck, Camille McGreevy
TITLE	Low Incidence Handicapped Children: An Administrative Guide.
INSTITUTION	Maryland State Dept. of Education, Baltimore. Office of Special Education.
PUB DATE	[78]
NOTE	124p.
AVAILABLE FROM	Maryland State Department of Education, Special Education Division, Information Management Branch, P.O. Box 8717, Baltimore, Maryland 21240 ($3.25)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	Equipment; Evaluation Methods; Facilities; Identification; *Individualized Programs; *Multiply Handicapped; Parent Role; *Program Administration; Screening Tests; *Severely Handicapped; Teacher Education; Teaching Skills; Transportation

ABSTRACT

Intended for local education agency administrators who are establishing programs for children with low incidence handicapping conditions (severe and multiple handicaps), the manual presents information on a range of program topics. Separate chapters are devoted to the following aspects (subtopics in parentheses): identification (presenting problems, Child Find implications); screening and assessment (multidisciplinary approach, protection in evaluation); admission, review, and dismissal process (interpretation of assessment data); individualized education programs (format, planning, establishing timelines); staff (teacher and aide competencies, ratios, related services staff); parents (education, resources); facilities (building design, safety, classroom design); equipment; materials (descriptions of texts and assessment instruments); transportation (legal requirements, emergencies); and funding (estimated breakdown of costs for typical facility). (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED170971

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

LOW INCIDENCE HANDICAPPED CHILDREN:

AN ADMINISTRATIVE GUIDE

Prepared by:

Camille McGreevy Peck, Chief
Program Development and Assistance Branch
Division of Special Education

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

MD State Dept of Education

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC114676

The following individuals made significant contributions to this manual:

Paulette Henson, Program Director of the Barbara Augustine Center, Anne Arundel County.

Howard L. Linaburg, the Information Management Branch, Division of Special Education.

Delbert Tweit, Principal of the James E. Duckworth Special Center, Prince George's County.

MARYLAND STATE BOARD OF EDUCATION

Members of the Board		Year Term Ends
Richard Schifter President	Bethesda	1979
William G. Sykes Vice President	Baltimore	1981
G. George Asaki	Pasadena	1982
Mary Elizabeth Ellis	Salisbury	1978
William M. Goldsborough	Oakland	1979
Joanne T. Goldsmith	District Heights	1980
Albertine T. Lancaster	California	1981
Lawrence Miller	Baltimore	1982
Charles E. Thompson	Baltimore	1980

SECRETARY-TREASURER OF THE BOARD AND
STATE SUPERINTENDENT OF SCHOOLS

David W. Hornbeck

DEPUTY STATE SUPERINTENDENT OF SCHOOLS

Joseph L. Shilling

ASSISTANT STATE SUPERINTENDENT
DIVISION OF SPECIAL EDUCATION

Linda J. Jacobs

The Maryland State Department of Education does not discriminate on the basis of race, color, sex, age, national origin, religion, or handicapping condition in matters affecting employment or in providing access to programs.

INTRODUCTION

A. Goals and Objectives

This manual is intended for the use of local education agency administrators who are establishing programs for children identified as low incidence handicapped. This identification applies to children, perhaps 1,000 of them in the State, whose current level of functioning has been affected by a combination of handicaps, the effect of which is so severe that appropriate curriculum goals for them focus on the prerequisites to self-care, communication, and some degree of movement and possibly ambulation. These children have a multiplicity of service needs and are served at Level V and at VI, where necessary.

Before initiating the procedures which lead to the placement of children and the delivery of services for children with low incidence handicapping conditions, it is critical that the school system specify not only its philosophy and commitment to the provision of service, but that it identify specific goals and objectives which it intends to meet within a specific timeframe. It is critical that a series of goals be spelled out and that everyone involved understands the implications of those goals and objectives for him/her in carrying out professional responsibilities. The school system must have a long-range and a short-range timeframe for accomplishing a total program. The support systems necessary should also be identified as they relate to specific objectives. That is, school boards, parents, the State Department of Education, individual administrators, and educators must take the responsibility of implementing certain components of the various

objectives. Without this, there is no direction and there is no way of assessing whether any kind of progress has been made, either from an administrative point of view or in terms of child progress throughout the program. This guide does not prescribe the goals and objectives a school system must have. It merely emphasizes that without the designation of these elements, the use of this guide or any other is without purpose.

B. Policies and Procedures

It is critical that every school system establish for the staff involved with low incidence handicapped children a set of very specific policies and procedures. How will services be delivered, who will have what responsibilities, and how will the daily operation of the school be handled? Three areas of particular importance which administrators should spell out in great detail concern physical management, personal care, and hygiene of the children. It should be established from the outset that these responsibilities belong to everyone in the school. Whereas aides have primary responsibility for physical care, such as changing soiled diapers, etc., all staff must respond as the need arises. The general cleanliness of classrooms and equipment, and whatever efforts are necessary for maintaining a clean,orderly environment must be detailed and must be monitored.

Another area which must be dealt with and planned for is the issue of emergencies. Staff must be advised as to precisely what will be interpreted as an emergency, and what procedures are to be followed for the various kinds of emergencies. It is strongly suggested that an intimate relationship be developed with the police department or the rescue squad to cover those rare instances when some type of emergency

medical or paramedical assistance must be provided. The critical factor is that specific procedures are available and are known to everyone. In whatever circumstance arises, there must be individuals who are responsible for dealing with the child in crises and other individuals who are prepared to deal with the other children as these occur. It is important that individuals react effectively in all situations. Not every seizure or every case of projectile vomiting amounts to an emergency. Everyone on the staff must be able to distinguish between the various kinds of situations that occur and to respond with appropriate behavior at the time.

Who needs this manual?

If the following needs exist among the population to be served in the program under consideration, this manual is relevant. If these are not the primary needs presented by some of the students, this manual will not be useful.

	YES	NO
1. Instruction Leading to		
Attending Behavior	___	___
Head Control	___	___
Sitting Balance	___	___
Ability to Eat Solid Foods	___	___
Self-Feeding	___	___
A System of Communication	___	___
Self-Toileting	___	___
Participation in Simple Forms of Recreation	___	___
Reduction of Self-Stimulatory Behavior	___	___
2. Physical and Occupational Therapy to Develop:		
Fine Motor Control for Basic Self-Care	___	___
Gross Motor Skill, Such As		
Sitting	___	___
Rolling	___	___
Crawling	___	___
Walking	___	___
Sensory-Motor Integration for Eye-Hand Coordination	___	___
Utilization of Communication Equipment	___	___

	YES	NO
3. Physical and Occupational Therapy to Provide Equipment and Alternative Systems for		
Locomotion	___	___
Toileting	___	___
Feeding	___	___
Dressing	___	___
Participation in Group Games	___	___
4. Speech and Language Therapy to Develop the Use of		
Receptive Language	___	___
Alternative Systems of Communication, such as		
Gestures	___	___
Signing	___	___
Communication Boards	___	___
Electronic Communication Devices	___	___
Self-Initiated Communication	___	___

If you have more than three "noes" per area, this manual is not for you.

TABLE OF CONTENTS

I. Identification 1

II. Screening and Assessment 4

III. ARD Procedures 13

IV. IEPs 20

V. Staff 29

VI. Parents 41

VII. Facilities 46

VIII. Equipment 55

IX. Materials 57

X. Transportation 63

XI. Funding 65

XII. Bibliography 67

Appendices:

A. Sample interview form -- University of Vermont Center for Special Education. Page 71.

B. Access to training -- the Comprehensive System of Personnel Development. Page 84

C. Description of Maryland's Direction Centers. Page 92.

D. State Association for Retarded Citizens Chapters. Page 93.

E. Information on Respite Programs. Page 94.

F. Information on Maryland Deaf/Blind Project. Page 110.

G. A Summary of Parental Rights and Responsibilities -- State Level Hearings. Page 111 and 112 (folder).

H. Surrogate Parent Guidelines. Page 113.

I. A list of State Department publications which are referred to in this manual. Page 114.

I. IDENTIFICATION

A. Presenting Problems and Need for Service

The children referred to as low incidence handicapped are those who are afflicted with multiple impairments which in combination occur infrequently in the population. One effect of these handicaps is severe to profound retardation. The children under consideration here are functioning below the two-year level. Frequently, there are severe physical or motor problems which may be due to cerebral palsy or some other type of brain insult. In some cases, there are severe sensory deficits, such as deafness and blindness. With regard to some children, there is significant behavioral disturbance, such as persistent self-stimulation and even behavior that is injurious and painful to the child. The population is viewed in terms of the child's current level of functioning. There is no requirement and there is no expectation that such children always function below the one or two-year level. The individuals addressed here are those children who currently perform that way. The goal is to raise their functional levels.

B. Current Placement of Children with Low Incidence Handicapping Conditions

At the present time in Maryland, the greatest number of low incidence handicapped children resides in State-operated facilities. Some are currently served in the public schools either within community public school buildings or in special centers. With respect

to number, only estimates can be given.

Norris Haring's information relative to the profoundly handicapped indicates that such children occur about at a frequency of one per thousand children. Given 900,000 school children in Maryland, one would expect that approximately 900 children in Maryland are severely impaired by multiple handicaps to such a degree that they could be included in the population which the Division of Special Education is calling the low incidence handicapped.

C. Implications for Child Find

It is difficult to estimate which children in this population have already been identified. Clearly, recognition of such severe handicaps is not difficult. At issue is whether or not such children are being excluded from the public school based on parents' belief that no public school services are available to them. It is important that Child Find efforts at the State and local level include a specific effort to reach those families who are not aware of available services. The fact is that not only is no child too handicapped to benefit from education, but further, no child is so handicapped that the right to education does not apply.

D. SSIS

For the purposes of filling out the SSIS form, it is suggested that Item 10, "multiply handicapped," be used in referring to these children. Clearly, there are many other handicapped children at a variety of service levels who have more than one handicap. However, it is the multiplicity and severity of the handicap which identifies these low incidence handicapped children. It refers to students for

whom, until the early seventies, public school special education did not provide programs. It is suggested the "multiply handicapped" category is the most appropriate of the options listed in the SSIS manual.

II. SCREENING AND ASSESSMENT

A. Screening as a Prelude to Assessment

As indicated in the Bylaw, all children must be screened for developmental delays or failure to meet milestones when they begin school. This is done at kindergarten entry or whenever beginning of school occurs. The issue of screening for children with low incidence handicaps must be fully explained. Obviously, such children cannot respond to the typical screening instruments that are used in general education or in special education. Therefore, there must be another screening vehicle, and it is advisable that each local education agency specify that screening vehicle for all such children. The purpose of the screening procedure is to identify children who have a reasonable likelihood of being handicapped. In the case of the low incidence handicapped, both the presenting characteristics and case histories establish the existence of handicaps. Thus, a detailed screening process is not critical.

Once the local education agency designates a specific screening procedure, then, according to the Bylaw, that process can be used as a first step. Those responsible for screening should review procedures they use in screening infants and preschool children. These can be used for screening the low incidence handicapped population. Instruments such as the Denver and the Vineland may work as adequate screening procedures. (Appendix A contains a sample interview form which is used in the program at the University of Vermont. This type of instrument could be used as part of the screening procedure.) Placement is based on the need for service

as determined through assessment. It is not based on cut-off scores.

B. Multidisciplinary Assessment

The issue of multidisciplinary assessment, of course, applies to all children who are being assessed for possible placement in special education. The requirement for multidisciplinary assessment has particular meaning with respect to children with low incidence handicapping conditions. At issue is not whether or not the child is handicapped, or whether or not the child needs special education services. In fact, that can be considered a given. What is at issue is the precise types of limitations the child has and the kinds of services that might be utilized to reduce or eliminate these difficulties or assist the child and family in compensating for the difficulties. Therefore, in assessing children with low incidence handicapping conditions, there must be a thorough developmental assessment. There must, in most cases, be audiological and ophthalmological evaluations. There must be an assessment by either a physical or an occupational therapist, an assessment by a communication specialist, and by a physician. What follows is a listing of the disciplines identified and a rationale for giving that type of assessment:

The developmental assessment: This assessment is made to determine where the child functions in a variety of areas in terms of age level. What is important here is not whether his/her feeding skills are at a two-year, one-month level, or two-year, four-month level but rather to identify where in the sequence of

attending, feeding, moving, and communicating this child is functioning in order to determine where the educational program should begin. An assessment must be done by an audiologist to determine whether or not there is hearing loss, and, if so, how severe. The possibility of cortical deafness -- those types of hearing losses where the hearing mechanism is intact but the receptive language process is malfunctioning or non-functioning -- must be determined. Optimally, this assessment is conducted jointly by the audiologist and the language therapist.

The ophthalmological and/or optometric evaluation: The degree of any visual impairment must be assessed and a determination relative to cortical blindness must be made. Again, the objective is planning of programs which address deficit areas.

A language evaluation: Critical in language evaluation is a measure of the degree to which the child is responding to any kind of language stimulation and perhaps making some form of language expression. Also, depending on the age and functional level of the child, the language therapist may begin to determine through assessment which approaches to communication might be tried with him/her.

An evaluation by a physical or occupational therapist: It is critical that an assessment be made of the child's fine and gross motor functioning and some implications or suggestions made with respect to neurological development. In most cases, either the occupational and/or physical therapist can do the assessment necessary for educational planning. It is clear to everyone that in the

process of providing either OT or PT treatment, the therapist incorporates further assessment into that therapy. In fact, the determination of the need for OT and/or PT assessment must be made at the local level based on the presenting problems and needs of the child and the particular expertise of the available OTs and PTs.

Finally, a medical evaluation may be called for, and if so, can be funded through education. A medical history must be obtained, but much more importantly, information about any of the child's physical or medical limitations must be given to the staff for planning the child's program. The physician will indicate the presence of seizures or the anticipation that a seizure disorder may develop, the appropriateness of a medication, if it is used, and the nature of other physical or medical conditions that are present. Any kinds of treatment that the child is already receiving must be considered in planning the total educational programs.

Also, where the child's medical condition renders him/her in any sense precarious or frail, the physician's report will indicate that and its implications for dealing with the child. Finally, the physician may want to specify any dietary needs which the child has, and he/she should be interested in closely following the child's educational progress. At the time of evaluation, a system of communication between the school and the private physician should be established.

1. Protection in Evaluation

Obviously, the regulations concerning protection in

evaluation apply to children in this low incidence population. It has been suggested that since the skills that are assessed in such children are skills that are valued across cultures -- that is, eating, standing, walking, talking, toileting -- there is less likelihood of cultural discrimination, at least with respect to assessment of these areas. These skills are not subject to cultural forces and experiences as are language, knowledge of American history, etc. All elements of protection in evaluation apply to the low incidence handicapped population. The assessment must be multidisciplinary. No placement may be determined by one test, by one procedure, or by one individual. Parent permission must be granted in writing before any assessment can be conducted. Parents have a right to know the results of the assessment. No assessment procedure may be used which penalizes the child for his or her handicap unless it is that area of functioning which is being assessed in that particular evaluation. For example, if a child's emotional adjustment of response to adults is being evaluated and it is known that the child is hearing impaired, verbal communication with the child should not be the primary method of determining his/her response to adults. On the other hand, if it is known that the child is hearing impaired, clearly some assessment of audiological functioning must be conducted, and the purpose is to determine the degree and the nature of the hearing loss. (For additional information, see the Protection in Evaluation Manual available from the Division of Special Education.)

2. Assessment as a Vehicle for Placement

The precise placement of a child cannot be determined until the assessment is concluded. The results of the assessment must be managed in such a way as to indicate what services are needed and in what environment they can be provided with as much contact with nonhandicapped peers as is meaningful to the children. There is an issue of logistics here, and it is important that individuals are placed on the basis of individual assessment results. Level V is typically the placement provided by the local school system. It must provide the multiplicity of services which the child needs. The Level VI option is to be used only when there is no other alternative. There must be commitment on the part of all involved in the decision, consistent with the commitment of the State, to bring children closer to their homes and closer to the normal environment. Furthermore, efforts must be made to reduce the number of children maintained in or referred to residential placement.

3. Assessment Instruments

There are a number of instruments now available for the assessment of children with severe and profound disabilities. Among them are the Learning Accomplishment Profile (LAP), the Topeka Association for Retarded Citizens (TARC) Scale, the Developmental Pinpoint Scanning Device, and the Callier Azuza. The sources of these instruments are in Section XII, Bibliography.

No instrument, no battery is sacrosanct. None is comprehensive. It is generally agreed by experts in the field

that an attempt to use norm-referenced tests, or standardized tests, is not appropriate. The existing norm-referenced tests typically do not go far enough down the developmental scale and do not refine the intervals between skills minutely enough. In addition, normative data are not informative in terms of instruction. The purpose of assessment is the identification of functional levels in various skill areas with an eye toward what should be taught next. It is important that each discipline have a systematic vehicle for assessment. Teachers will find that physical therapists and occupational therapists have few usable formalized instruments, particularly for the assessment of very severely involved children. They will, however, have a developmental and neurological orientation which will bring out the motor functioning level of the children in question. The construction of objective assessment instruments for fine and gross motor skills in severely impaired children is a goal of the Division of Special Education.

4. Baselines

Perhaps one of the most useful approaches in assessing the behaviors of these children is to identify simply the frequency with which certain behaviors, either positive or negative, occur. Baselines should be taken in the same situation with the same cues over at least a three-day period, if that is possible. In some cases, a baseline will be taken which turns out to be simply a consistent observation of the absence of behavior. That is to say, there may be no eye contact from a given child

in a given type of situation when he/she is observed in half-hour periods over a number of days. By contrast, one may be able to identify a pattern of head-banging if observation conditions are varied. It may be identified that as noise level increases, the rate of head-banging increases. These baselines can be effective starting points for the planning of a program and also useful measures for assessing child progress.

5. Daily Assessment

In the absence of daily data, no determination about progress can be made. What is most important is that in the absence of progress over a specific amount of time, some systematic change in instruction must be made.

A final point should be made with respect to assessment. It is important in the preparation of an assessment report leading to an IEP meeting that the process of assessment not overpower the entire program. What is critical is the identification of a few target areas toward which the program will be directed. The State Bylaw has set timelines with respect to assessment and implementation of the IEP. There is no reason for the assessment of children in this population to be stretched out beyond these timelines. The IEP should be designed to address those behaviors which appear to be of major importance at the time it is written. With the use of daily assessments, objectives can be changed and program revisions can be made in the IEP at the point of the 60-day review. An error that is

often made in serving children with complex and intense handicaps is that energies go into assessment which in fact simply gild a lily and postpone that moment at which some program is tried, cast aside, reshaped, or pursued depending upon its effectiveness. Further discussion of assessment is found on pages 23-25 under IEPs.

III. THE ADMISSION, REVIEW, AND DISMISSAL PROCESS

A. The Makeup of the Committee

The ARD committee must include the child's teacher, all of those who have been involved in his/her assessment, and an administrator familiar with special education programming. It is absolutely critical that what Skipper, Wilson, and Wolf (1977) refer to as a linear or straight-line placement process be avoided. That is to say, the members of the ARD committee must be equal members of that team. No one by force of personal power, degree earned, discipline represented, or status, should be in a position of holding ultimate decision-making power. Clearly, someone must chair the process; clearly, there must be an organizational structure and a direction; but each discipline and each individual must have an equal part in the ultimate decisions made and submitted by that committee before a final delineation. It is suggested that rotating chairpersonship of the committee might be best. In addition, the recording of minutes and conclusions of the ARD committee by a secretary is an essential procedure and a great simplifier.

B. The Staffing Process

The concept of staffing, in the sense of transdisciplinary planning, is new to the public school situation. The term "transdisciplinary" refers to that cooperative process whereby each member of the professional team shares his/her expertise with the others and expands his/her role to incorporate the techniques of other disciplines so that each person is to a degree a deliverer of the child's total program. Physical therapists learn to encourage language development; teachers learn positioning and feeding skills, everyone learns measurement and behavior management. It is important that a procedure workable for a given school be set up and

followed. The greatest complaint that is heard around the State with respect to special education legislation is the amount of time that new requirements take. One particular difficulty is the time required for meetings. It is essential that guidelines are set up for ARD meetings which minimize time and maximize output. Individuals must be informed well in advance as to which child will be discussed. They must be required to bring typed reports to the meetings; meetings must start and end on time; follow-up reports must be submitted within a specific timeframe. In addition, details like report format, strict adherence to a prescribed structure for a child's folder, and very clear delineation of how information will be communicated must be followed. Individual staff members must understand that decisions about children's programs are not made outside the ARD and the IEP committee meetings. There must be vehicles for changes in program, for revision of the evaluation plan, and for any redirection with respect to the child's placement or program. This is not only an issue of efficiency; it also relates to due process in terms of confidentiality, in terms of keeping parents informed of all proceedings, and in terms of keeping an organized record that can be readily understood by all who have rightful access to it.

C. Interpretation of Assessment Data

Assessment data provide the primary basis for planning. Clearly, scores in isolation are relatively meaningless. Each individual who conducts an assessment must prepare a brief and succinct explanation of what that assessment indicates. Of monumental importance with respect to the ARD process is the ability of that committee to compile all of the assessment information into a description of the child's current need for service.

As anyone who has worked with a multidisciplinary assessment system readily realizes, not all assessment data support the same interpretation or same theory or the same plan for describing the child's limitations and designing his/her program. The committee must have the expertise to weigh varying kinds of information, to make some hypotheses about the way to proceed, and to return and evaluate their initial judgments against data gathered later. There is no question that individual assessors differ. In spite of great commitment and professional skill, there is typically some examiner bias. What is important is that the committee be aware of this. It is highly beneficial to have a standing team looking at the same group of children, and discussing and refining its overall process of assessment. Often the ultimate truth about a child's condition and need for service cannot be found through an analysis of assessment data. It is important, therefore, to define what the committee sees as the most reasonable and parsimonious interpretation and to proceed with a workable plan. In many cases one is in an "if-then" situation; i.e. <u>if</u> this indeed is the true need for service, <u>then</u> the specified treatment should help. <u>If</u> it doesn't, <u>then</u> perhaps that wasn't really what the child needed. It is not always possible to have total vision with regard to these things at the very beginning of a child's program. Most parents would prefer that some decision be made and that the school get on with the program rather than engage in a prolonged diagnostic procedure. The programs and IEPs are not sacred. They can be changed in the presence of new data.

D. <u>Appropriate Referrals</u>

The referral process is to a certain extent unique to the school and community in which it takes place. The ARD committee must know what services are available. It should always start with the services that are available within the school system. Where the complexity or severity of

the child's conditions are such that assessment services beyond the school's capability are necessary, then community agencies and, if necessary, State agencies ought to be contacted for the services needed. It is important that the community monitor the kinds of referrals that are made so that evidence for additional services can be presented to the county council, the health department, and the State Department of Education with the objective of increasing local resources. The decision about referrals should be made on the basis of what is needed, not on what is the most sophisticated or elaborate. It is sometimes assumed that a given evaluation can occur only at institutions bearing prestigious names. This is not always correct. Frequently, a local agency which would provide the needed service exists and is not considered. Another consideration is the amount of time needed to acquire the service for which the child is referred and the amount of procedure involved in the referral service. It may be possible to create or identify an interim measure while a child's name ages on a waiting list. ARD committees should also monitor the effectiveness with which various referrals are followed. Both in terms of incoming referrals and referrals that the committee makes, it is important to know which pediatricians pick up most acutely the children with serious handicapping conditions and make the appropriate recommendations to the school. It is also important to know which services within the community and within the State give the most rapid response to the need for audiological or ophthalmological evaluation, etc., and which ones send back the most meaningful information. Those agencies which function effectively obviously should be reinforced and used frequently. Such agencies might also provide resources in the development of local or school services.

E. The Role of the Health Department

At this time, the health department has no mandate to serve handicapped children in education. However, in a number of counties throughout Maryland, very satisfactory systems of health service have been arranged with local health departments. It is critical that each local education agency foster this kind of service to the largest extent. There are many models for the relationship between health and education; there is no attempt on the part of anyone to create just one. This relationship should be designed locally. The health department may have services useful to the school of which the school is not aware. In addition, the school may have needs of which the health department is not aware. It is critical that they pool energies in an attempt to maximize services to handicapped children at all levels. Whereas the law cannot require the participation of health department individuals on ARD committees, it is important to point out that the State Health Department requested the inclusion in the Bylaw of health department staff on ARD committees. This statement in the Bylaw does not mandate that behavior but certainly indicates to local education agencies that they ought to encourage health department participation.

E. Placement

Placement decisions are the responsibility of the ARD committee, contingent, of course, upon the parents' agreement with the placement. The issue of service levels is a major consideration. It is critical that the child get the service he/she needs. The children considered here have multiple service needs. The geography, the facilities, the

administrative organization of the local education agency -- all bear on the degree to which these services are available. The delivery of service is the first order. At an administrative level, school systems ought to look to decentralizing services, so that it is not necessary for any child to go to a specific center in order to get any kind of physical therapy, occupational therapy, or intensive speech and hearing training. At the same time, the availability and access to the services is primary in the development of the child's program. Next in importance is the issue of least restrictive environment. Ideally, children with low incidence handicaps can be served at Level V, a special center, or special wing. Within the special center, arrangements should be made for some contact after school, through Special Olympics, or through a variety of other kinds of activities with nonhandicapped or with less handicapped peers. In addition, the strategy of involving nonhandicapped children who may be interested in working with the handicapped as part of their educational or extra-curricular programs ought to be explored carefully. Most important of all, a special center should be designed to serve moderately handicapped children together with the low incidence handicapped. A separate facility which serves only this latter population is extremely ill-advised, both in terms of least restrictive environment for students and of staff interaction. Finally, the Level VI option exists. It should be reserved for those children who must have 24-hour programming due to their educational needs.

G. Review of Placements and Programs

The Bylaw requires that the ARD committee take the responsibility of reviewing placements after 60 days and on an annual basis. In considering the intensity of service designed for children with low in-

cidence handicapping conditions, it is necessary to evaluate thoroughly the nature of the placement and the possibility that the placement should be changed. The objective is always to move the child to a less restrictive placement, that is, from six to five, five to four, where possible. Logistics must not entirely dominate those decisions. Another element of the review of placement and programs concerns the practicality of the program that is being provided. That is, does the IEP describe services that can reasonably be expected to improve the child's level of functioning? Each individual service must be looked at from this point of view. These are often difficult decisions. At what point does one decide that a child will not communicate through verbal methods and must use a communication board? At what point does one decide that a child will spend the majority of his/her time in a wheelchair, and that the physical therapy program which has focused upon standing, balance, and walking should be redirected? These are not decisions that can be made in a short period of time or by one individual. They are decisions made on the basis of accumulated data. In addition, rarely is it necessary to make black and white decisions. One may introduce a communication board without eliminating instruction for speech. One may certainly introduce a wheelchair for certain types of locomotion while not terminating treatment approach that emphasizes walking. However, with some children there comes a point when direction must be changed. The ARD committee as a group in cooperation with parents must make these decisions.

IV. INDIVIDUALIZED EDUCATIONAL PLANS

A. Format

The format for the Individualized Educational Plan which has been developed by the State Department of Education may be used also for low incidence children, as may any other format that the local education agency selects as long as the various components of the IEP are included. That is to say, there must be indications of current-level functioning in each major area. There must be long-range goals and short-term objectives. There must be identification of the strategies with which those objectives are to be met and the kinds and amounts of services to be provided. There should be an indication of the duration of service, the amount of contact, if any, with nonhandicapped peers, and the establishment of criteria for evaluation of the child's progress toward each objective. In addition, of course, all IEPs must be signed by the parent or guardian of the child.

1. The standard MSDE format for IEPs is on the pages following this section.

2. Modifications of this format might include a more comprehensive section on "Summary of Results." This would help staff be more specific in prioritizing short-term objectives and in describing current functioning. In addition, the form may be designed so that it can also serve as a progress report for parents. If long- and short-term goals are listed carefully, the criteria section would become a definitive reporting device for parents. In fact, the format could be designed so that annual and long-term goals are not repeated and do not duplicate each other. Finally, whatever form an IEP

for low incidence handicapped children may take, it is important that it be a functional working tool -- both as a teaching aid and as a resource for parents.

B. Planning

1. Setting Priorities and Identifying Goals

In identifying the goals for children in this population, one is looking at basic attending, self care, and communication skills. This population is heterogeneous. There is no set of specific objectives which can be prescribed for any group. However, what must be identified are those skills which would seem to be attainable. One must look at ability in a variety of areas. There are children who can learn to read who will never sit. There are children who will learn very complex fine motor behaviors who will never speak. There are children among orthopedically impaired, for example, who never obtained bowel and bladder control but who obtain Ph.Ds. It is important not to expect that because a child is extremely limited in one area there are parallel limitations in other areas without comprehensive assessment. Sometimes this is the case; often it is not. Therefore, it is suggested that each child be looked at individually and that the team, in developing the IEP, specify goals that are reachable and that are valuable. Behavior can be looked upon as a left-to-right distribution. If one looks at the fine motor behavior, the most extreme negative behavior would be that behavior which is injurious to other children or

to the child himself. At the midpoint in this distribution there is simply no behavior. This is given a weight of zero. Everything to the left of this midpoint is given an increasingly negative weight. To the right of the midpoint is neutral or irrelevant volitional behavior followed by behavior that is directed by an adult to behavior that is productive and is initiated by the child. This is located at the farthest point to the right. One must judge where the behavior a child shows fits on this line and decide what behavior will be the focus of IEP goals. Presumably, one would be more concerned with extinguishing head-banging than with extinguishing teeth-grinding or more anxious to increase vocalization than to shape finger-tapping. One very viable way of determining these goals is to identify those behaviors about which the parents express the most concern. It is possible that the finger-posturing or ruminating are more noisome to the family than is the fact that the child has not been toilet-trained, and that is a fact that ought to be considered. It is also possible that the family is not identifying certain eating patterns or self-stimulation patterns as self-destructive. The child's comfort should be considered. It may be that teaching a child to master a certain kind of sitting position is more related to his comfort at the present time than his ability to master bladder control. Clearly those things which would lead toward the child's safety, health, or comfort carry a very high priority. Clearly, it should never

be the intent of the staff to simply keep the child comfortable. The child should be taught those skills which will be reinforcing to him in the sense of making him comfortable and interested.

Another major element in identifying goals is related to the child's general strength and medical condition. The feasibility of specific goals needs to be considered by the physician in charge of the child's medical well being. For example, ambulation may cause serious hip damage in some children.

2. Obtaining Baselines

As was indicated above, frequency data can be kept on children in precise situations over a specified period of time. This should be done when feasible. If a child is in constant tantrums, it is impossible to get data on how often he would feed himself, given the optimum situation. In that case, what one takes data on is the frequency and the duration of the tantrums. If the child in question evidences no behavior, one may wish to set up very specific situations in an attempt to elicit behavior. Even behavior such as a startle response, a knee jerk, attention to sound, or eye tracking should be monitored in such cases. Here one wants to set up very precise conditions so that it can be determined under what conditions the response is obtained. It is critical in obtaining baselines that the individual taking data know precisely what is being counted and how to count it. This issue must be made very clear, so that when instruction is being designed, the starting point is evident. With respect to baselines, it is important to take data in a variety of settings, so

that antecedent factors can be considered when data are analyzed. The effects of medication, for example, and the time at which it is given may have significant bearing on the child's degree of attention, his/her response to stimuli, his/her willingness to cooperate with an adult.

3. Specifying Baselines

It is critical that objectives be very specific. A point might be made here with respect to the number of objectives. It has been suggested by Kenowitz (1977) that four objectives or target areas per evaluation period are appropriate. It is further suggested that four programs, i.e. four skill areas, are probably close to the maximum that a child can handle in the classroom setting. In any case, the objectives must be very specific: they must be child-centered, and they must be measurable. This means that behaviors are defined in terms of movement cycles and may be measured in seconds. For example, "the child will hold his head at midline for 10 seconds." "The child turns to the speaker on command." "The child imitates clapping." "The child will track an object on a long 180-degree curve." "The child's clothing is kept dry for two-hour periods." "The frequency of head-banging is reduced from 50 times a minute to 10 times a minute."

4. Describing Activities

On the IEP it is necessary to indicate the kinds of activities in general that will be used in the education of the child. An example is "one-on-one instruction with specified materials for 20 minutes per day, to establish head control." When the actual teaching plan is written, the precise procedure for instruction is spelled out in great

detail. It is not appropriate to do this in the IEP.

5. Establishing Timelines

a. External Deadlines

The Bylaw requires the IEP be implemented within 30 days after it is written and approved by the parents and the ARD committee. It is also to be reviewed within 60 school days after its start. These are mandated deadlines and cannot be altered.

b. Internal Deadlines

It is necessary to make estimates about how long it will take a child to learn a given task. It should be made very clear that, particularly with these low incidence handicapped children, one is dealing strictly in estimates, and there are no solid data at this point which would make the prediction very strong. The point is that within the weekly development of the child's program, some determination must be made that after a specific time some modification will be made if no improvement is seen. Obviously, many variables must be looked at with respect to learning curves, and a variety of factors bears on the child's performance. The essential point is that one does set timeframes and attempts to determine whether the objective was met, and if not, why not. It will be important for administrators and teachers in these programs to monitor the amount of time that it takes for children to learn certain skills according to certain methods. Accumulating these kinds of data will improve the ability to predict and to have data-based judgments for determining when a given treatment is not workable for an individual child, or is workable and may apply

to other similarly handicapped children.

6. Delineating Evaluation Criteria

The evaluation criteria for the IEPs can be, in fact should be, the same statements that were used as short-term instructional objectives. "The child holds his head at midline for 10 seconds." "The child can track an object for a long 180-degree curve," etc. Each is an objective, and each is an evaluation criterion.

7. Special Subjects

Under the requirements of P.L. 94-142, all handicapped children must have physical education. The goals of this program must be reflected in the child's IEP. Often in the case of severely impaired children, physical education goals and objectives will be related to basic motor development.

Music and art must be provided to the low incidence handicapped if it is provided to the nonhandicapped in the school system. The activities must be adapted so that students can actively participate as is feasible in terms of their limitations.

INDIVIDUALIZED EDUCATIONAL PROGRAM: TOTAL SERVICE PLAN

Local Education Agency:
Name and Number _____

School _____

Name of Student _____

Date of Birth _____ Age _____ Grade _____

Description of Educational Placement Recommendation:
Special Education Program Model _____ Hrs/Week _____ Regular Education _____ Hrs/Week _____

Legal Category of Exceptionality (for funding purposes only) _____

Summary of Present Levels of Student Performance:

Program Goal(s)	Specific Special Education and/or Related Services	Person(s) Responsible For Implementation	Hours Per Week	Starting Date	Projected Ending Date	Annual Review Date (Mo-Yr)	Child Study Team Recommendations: Methods & Materials—(If appropriate)	Evaluation Criteria

CHILD STUDY TEAM MEMBERS PRESENT

Signature	Position	Agreement with IEP: Total Service Plan (Check appropriate space) YES	NO	Date of Child Study Team Meeting:

-27-

INDIVIDUALIZED EDUCATIONAL PROGRAM: IMPLEMENTATION/INSTRUCTIONAL PLAN

Name of Student _____ Date of Birth _____ Age ____ Grade ___ School _____ Local Education Agency Name & No. _____

Date of Entry into Program _____ Projected Ending Date _____ _____
(Signature of Implementor Completing this Form)

Program Goal(s)	Implementation/Instructional Objectives	Strategies and/or Techniques	Materials and/or Resources	Date Started	Date Ended	Criteria for Mastery of each Implementation/ Instructional Objective

V. STAFF

A. Teachers and Aides

1. Competencies

A great deal of discussion has taken place concerning skills needed by teachers of children with low incidence handicaps and skills needed by aides. In reality, both levels of staff must have many of the same competencies. The major distinction between the roles of teachers and that of aides is that the teacher interprets the assessment data, plans the program, determines the point at which the program shall be changed, and assigns responsibilities and supervises the aide. In addition, teachers conduct full-scale assessments and participate on the IEP and ARD committees which aides do not. The major competencies which are essential in providing services for the children described here include but are not limited to the following: the ability to pinpoint behavior; the ability to specify very precise instructional plans for the acquisition of desired behavior; skill in the reduction or extinction of undesirable behavior, and the ability to take a variety of data appropriate to the targeted behavior; knowledge of strategies for cooperating with language, physical, and occupational therapists in implementing the various programs they design. This includes implementing systems for nonverbal communication, positioning, and a number of techniques for developing self-care skills. Teachers and aides must be able to employ behavior management techniques as they apply to this population. In addition, they must be able to describe and design, and, in many cases, actually

construct or modify equipment and materials for the instructional program. Also, it is important that teachers are able to manage the logistics of planning with individuals from other disciplines and the logistics of scheduling the child's day to maximize opportunities for instruction. Teachers and aides must adapt the program around various elements of the school program including consideration of space, toileting facilities, transportation, and food services.

To a lesser extent, teachers and aides need to know the nature of the conditions with which the children are affected. The importance of this cognitive skill relates to those conditions which may have educational, personal care, and/or dietary implications, such as spina bifida, cerebral palsy, and certain other conditions, e.g. Usher's syndrome, which have specific implications regarding possible hearing loss or other sensory disabilities.

2. Ratios

At Level V, the Bylaw requires a ratio of one teacher to a maximum of seven children with an aide, where children have significant physical impairments. Obviously, the school system may elect to provide additional staff. Clearly, in the instructional setting, there must be provision for a one-on-one instruction so that only for those activities in which the total group can participate is there really an ongoing interactive ratio of two adults to seven children. More commonly, teachers and aides work with individual children or with pairs of children. Also, in the day-to-day programming process, children are receiving services from individuals from other disciplines while they

are in the classroom setting. In this way, one isn't dealing with a continuous full-day program, where seven children are being dealt with continuously by this same teacher and aide.

3. Roles

It is most efficient if both the teacher and the aide take the position that they are jointly implementing a series of programs. The teacher must have the supervisory role, of course, but both individuals must have a commitment to shaping behavior, following the schedule, providing personal care as needed, taking data, and responding in general to the needs of the children. There is considerable personal care involved in programming for children afflicted with low incidence handicapping conditions. It is simply not efficient to have a hierarchy of staff where only a certain class of staff deals with feeding, toileting, and cleaning up messes. These activities must be done by the person who is most conveniently available when the service is needed. A further point should be made with respect to the role of the teacher. It is critical that the teacher expand his/her role in order to implement directly techniques and programs from other disciplines. At best, the teacher functions as an individual who presents and provides not only instruction, but a program which includes concepts, materials, and principles from other disciplines.

B. Related Services Staff

1. Competencies

As was said above, it is absolutely critical that physical therapists, occupational therapists, and language pathologists be available to the program for children with low incidence handicapping conditions.

The competencies of these individuals will in reality be determined by the kinds of training they have received. The assignment of respective staff within programs has to be made along these lines. It is essential that the following competencies be available somewhere among those individuals who provide PT and OT.

a. the ability to conduct a neurological assessment relative to the delivery of their services,

b. the ability to develop instructional programs which lead, where appropriate, toward the development of normal patterns in the child or, if necessary, development of compensatory skills,

c. the ability to prevent through treatment, increased disability wherever possible,

d. the ability to improve the child's gross and fine motor functioning,

e. skill in establishing prerequisites and in many cases the actual skills involved in functional behavior such as toileting, feeding, breath control for speech, and dressing,

f. the ability to provide objective evaluations of the child's performance,

g. the ability to teach language and encourage language in the process of developing motor skills,

h. the ability to cooperate in shaping and reinforcing behavior that the teacher wants to encourage, which is not directly related to motor skills, such as eye contact, vocalization, etc.,

i. the ability to take data on specific behaviors day-to-day, which are related to the behavioral objectives established for the child,

j. the ability to train teachers, aides, and parents in implementing individual elements or therapy programs for children, and

k. the ability to adapt equipment, identify need of equipment, and make recommendations for the use of furniture, buildings, and space in general, for children with severe physical impairments.

Speech and language pathologists need the following skills:

a. the ability to do thorough assessments, not only of speech and gestures, but of receptive language and behaviors that may suggest internal manipulation of symbols by the child,

b. skill in developing individualized systems of communication for children with varying kinds of handicaps and in teaching the systems to teachers, aides, and parents,

c. the ability to take data on a child's progress toward objectives and the ability to reinforce behaviors or ignore those not directly related to speech and language, but on which the teacher is focusing,

d. skill in ordering, adapting, and using various kinds of equipment such as hearing aids and cybernetic or electronic equipment needed for certain children, and

e. the ability to implement positioning techniques and direct children in the use of appropriate movement patterns.

Vision therapists who work with low incidence handicapped children must demonstrate the ability

a. to develop auditory and kinesthetic awareness,

b. to initiate and develop mobility skills in children, including sitting, crawling, standing, climbing, etc.,

c. to conduct sensory awareness training.

d. to facilitate the use of low vision in children who have some sight, and

e. to utilize various devices in the development of tactile and auditory skills and low vision skills.

Staff with competencies associated with nursing services must be available. There are a number of procedures, such as postural drainage, management of colostomies, etc., which must be done for some children due to the nature of their conditions. It is the responsibility of the principal and the school system to make arrangements as follows:

a. identify those areas in which a physician's orders or approval are necessary,

b. provide training for selected staff in the implementation of specific procedures, (In most cases, aides can carry these out if adequately directed.)

c. obtain information from parents (or from the child-care staff in the student's residential facility) regarding the management of such procedures with individual children,

d. obtain necessary materials and equipment and establish a location(s) for the implementation of the procedures, and

e. describe in writing which individuals will do which procedures and under what circumstances.

In those rare instances where a child is seriously vulnerable to physical distress and life-threatening complications, a designated person must be responsible for him/her in each setting. The fact that

the death of a child can occur in a school setting must be faced squarely by those who work with this population and by the parents. This knowledge must be raised to consciousness, discussed, debated, and understood in order to decrease free-floating anxiety and guilt.

2. Ratios. Specific ratios for related services staff to children with low incidence handicapping conditions are not available. It is the judgment of the Division that such children should not be grouped together in isolation from other less impaired children. Therapists would be assigned not to a total population of low incidence handicapped children but rather perhaps to a special center or wing that serves children with a range of disabilities at Level V. In this kind of setting, it is tentatively suggested that one PT, one OT, and one speech and language pathologist for 75 children may be a functional staff ratio, assuming that the staff is full time, does not travel among facilities, and provides primarily evaluation and consultant services to the majority of the children. It is estimated that one vision specialist per 75 children is needed. It must be recognized that these ratios are a part of planning guidelines. If children's IEPs require more services than can be provided with these ratios, more staff must be added.

3. Roles of Related Services Staff. It must be made clear that the related services staff is an integral part of the special education program. Roles must be developed reciprocally. The objective here is a trans-disciplinary staff where each individual expands his/her capability toward delivering the total program. Therefore, the role of each is to share the expertise which he/she possesses. In addition, each

individual must establish his/her role to fill those areas most needed. If an occupational therapist has not developed the ability to design feeding programs for children with severe swallowing and tongue thrust problems, the speech pathologist might, or vice versa. Ultimately, both individuals must develop enough skill in feeding instruction to meet the need. These things can only be worked out in an individual center depending upon the training and experience of the available staff. There should not be undue concern with overlapping skills. It is to the child's advantage to have carryover all day relative to his/her progress. In addition, the OT cannot possibly do all the feeding training, nor can the speech and language therapist do all the communication training. It's appropriate that the teachers, the speech pathologist, and the occupational and physical therapists all focus on these areas.

C. Recruitment and Selection of Staff

The selection of educational staff should be based on the training and experience of the available candidates. It is suggested here that a trial period in working with the low incidence handicapped population may be provided through a pre-employment summer workshop or some kind of consistent contact with these children before employment is fully contracted. This applies obviously to cases in which individuals are hired who have not had direct experience with children with profound limitations. The recruitment of PTs and OTs is a very complex issue, since very few are available in Maryland and the surrounding area who have experience with children, particularly with children who have the multiplicity of handicaps described here. It is clear that recruitment

should include the involvement of other therapists from the same disciplines and should not be managed by educators alone.

D. Supervision of Staff

It is imperative that all staff be supervised by individuals who know more about the program to be implemented than do the staff members. Therefore, there must be a supervisor of instructional staff who has a solid understanding of the nature of programming for children with low incidence handicapping conditions. It is equally critical that individuals who provide therapies are supervised by people trained in these areas. It appears at this time that it may be necessary to have either an OT or a PT supervise individuals from both professions. This is not ideal but pragmatically it may be the only option in some areas. Supervision of speech and language therapists has been established so that in at least the large LEAs this staff is well supervised. This is the model that should be followed with respect to physical and occupational therapists and also with individuals implementing programs related to visual and visual-perceptual skills.

E. Personnel Preparation

1. LEA Inservice. The Bylaw requires that the local education agencies provide inservice to staff. Such inservice is particularly critical for staff members who work with the low incidence handicapped, since many training institutions do not equip staff with the competencies needed. In addition, it is critical that inservice be maintained, scheduled for, and reinforced so that the role expansion described can occur.

2. Inservice Through the Division of Special Education's Comprehensive System of Personnel Development (CSPD). The State provides inservice to local education agencies. This is one of its responsibilities as prescribed by P.L. 94-142 and the Bylaw. A copy of the manual on the CSPD is available through the Program Development and Assistance Branch, Division of Special Education. Specific information about this inservice and the variety of types of programs available is provided in Appendix B of this manual.

3. Training Institutions.

   a. Special Education. The following institutions of higher education offer approved special education teacher preparation programs:

      Bowie State College, Bowie, Md.

      Coppin State College, Baltimore, Md.

      Hood College, Frederick, Md.

      Johns Hopkins University, Baltimore, Md.

      Loyola College, Baltimore, Md.

      University of Maryland, College Park, Md.

      Western Maryland College, Westminster, Md.

   b. Physical Therapy. Professional education in physical therapy is available through the Department of Physical Therapy, University of Maryland, Baltimore, 21201.

   c. Occupational Therapy. Professional education in occupational therapy is available through the Occupational Therapy Department, Towson State University, Towson, 21204.

d. Preparation of Paraprofessionals. There is limited preparation for paraprofessionals specifically working with low incidence handicapped children. One of the obstacles is that currently there is no certification system in the State for paraprofessionals. Dundalk Community College has an aide-training program which focuses on what that school calls "paraprofessionals to work with severely and profoundly handicapped."

4. Certification. At the present time, Maryland provides a general special education certification system. However, a new certification program is currently being developed by the Division of Special Education and the Division of Certification and Accreditation. It is expected that, following approval by the State Board of Education, the actual program will be in operation in 1980. It is only after that time that the issue of certification of paraprofessionals will be addressed. Occupational and physical therapists are licensed under their own professional organizations and by the Department of Health and Mental Hygiene, the State of Maryland. An additional goal of the certification system operated by the State Department of Education is to address the establishment of criteria for OTs and PTs working in education. Speech and language therapists who work in public school programs are certified by the Certification and Accreditation Division of the State Department of Education, as teachers are.

5. Professional Organizations. Teachers of children with low incidence handicapping conditions may most closely identify with the American Association for the Education of the Severely and Profoundly Handicapped. This is a national organization which has its

administrative offices in Seattle, Washington. In addition, the Council for Exceptional Children in Reston, Virginia, has a division for those members who are particularly interested in the severely and profoundly handicapped. Physical therapists are typically members of the Maryland chapter of the American Physical Therapy Association. In addition, they may belong to the Pediatric Section of the APTA. Occupational therapists belong to the American Occupational Therapy Association. Speech and language therapists might belong to the American Speech and Hearing Association. These organizations provide not only educational information and intradisciplinary contacts, but set standards and conduct lobbying efforts in the interests of this membership.

VI. PARENTS

Parents have a specific role in the educational programming for children with low incidence handicaps? "Parent" in this connection should also be understood to mean guardian and, where appropriate, ward aide or cottage staff.

A. Parent Education

It is the responsibility of the local education agency to provide education to parents in terms of programming for and care of their handicapped child. In no case should parent participation in the child's program or in parent training be a requirement for the child's enrollment in the program. The Bylaw requires that no parent of a handicapped child be required to perform any activity or participate in any event where parents of normal children are not required to do the same thing. Parent education covers a range of options. These include home training; assisting people and parents in devising systematic schedules of instruction, and reinforcement and positioning; modification of equipment; and modification of the home setting in order to foster the child's growth and to facilitate the child's development of skills. Parent education may also include group instruction provided to parents regarding not only programming, but also regarding their rights, their access to resources, and their roles if they so choose, as advocates for their children.

B. The following resources are among those that are available to parents. They are listed here briefly with references as appropriate to the Appendix.

1. The Direction Centers. The Direction Centers are federally-funded agencies operated by the Division of Special Education and located around the State. Their objective is to refer parents to a variety of available services, not only in education, but in other disciplines where they may have needs. More information on this is available in Appendix C. The manual on the Direction Centers may be obtained from the Information Management Branch of the Division of Special Education.

2. Maryland Association for Retarded Citizens (MARC). This is a very active parent organization which has a local organization in every county. It was MARC that brought the class action suit which resulted in the right-to-education legislation established in the spring of 1973. More information on MARC is in Appendix D.

3. Respite Programs. The list on the two pages following this section identifies respite programs in Maryland by geographic area. Detailed information is attached in Appendix E.

4. Deaf/Blind Project. Some children referred to as deaf/blind fit into the population referred to as low incidence handicapped. A variety of resources is provided to these children both in public school and institution programs. Additional information on this project may be found in Appendix F.

5. Due Process Procedures. Federal and State laws provide an important series of rights concerning parents, their children's education, and the communication process surrounding the identification and evaluation placement and review concerning special education services

for their children. A summary of these procedures is found in Appendix G. A parents' handbook called "Legal Rights" is available through the Program Development and Assistance Branch of the Division of Special Education.

C. Parent Substitutes.

Children with low incidence handicapping conditions are often in situations which include parent substitutes. These individuals must be included as recipients of information and training.

Surrogate Parents. The State has a surrogate parent program. Details about this may be found in Appendix H. Briefly, surrogate parents are appointed when no one is available to represent the legal and educational programming rights of the child.

Institution Staff. It is critical that programs be provided for institution staff which allows it to support, in whatever way possible, the instructional program that is established for the child in school. Competencies needed by aides are similar to those needed by the teachers. It is particularly essential that aides can follow through on the physical management and behavior management procedures to be used with the individual child. It is also necessary that aides are able to collect a number of kinds of data-taking procedures and that they are able thereby to monitor consistently the children's progress. Aides as well as teachers must be able to take care of the personal hygiene of all the children in such a way that the child's health and cleanliness needs are met and also in a way that assists the child in learning as much self-care as possible. This is vastly different from the provision of custodial care.

RESPITE PROGRAMS IN MARYLAND

BALTIMORE METROPOLITAN AREA

1. Chimes, Inc. Respite Care
2. Family Resources Program
3. Gallagher Center Respite Care
4. Highland Health Facility Respite Care
5. Rosewood Center Respite Care
6. United Cerebral Palsy of Central Maryland Respite Care Programs
   -- "Oh What A Relief It Is"
   -- Homestyle Care
   -- St. Vincent's Child Care
   -- Mt. Washington Pediatric Hospital Respite Care

CENTRAL MARYLAND

1. Anne Arundel County Respite Care
2. Bell Machre Respite Care
3. Carroll County Department of Social Services Respite Care
4. Crippled Children's Society - Easter Seals
5. Harford County Respite Care
6. Henryton Center Respite Care
7. Howard County Respite Care
8. Montgomery County Department of Social Services Respite Care
9. United Cerebral Palsy of Central Maryland Respite Care Program
   -- Hyattsville Manor Respite Care

EASTERN SHORE

1. Holly Center Respite Care
2. Eastern Shore Homemaker Services
3. The Mid-Shore Respite-Relief Care Programs

SOUTHERN MARYLAND

1. Great Oaks Center Respite Care
2. Prince Georges County Department of Social Services
3. Helping Hands for the Handicapped - Charles County Respite Care

Proposed Program: St. Mary's County Department of Social Services Respite Care

WESTERN MARYLAND

1. Crippled Children's Society - Easter Seals
   -- Home Care Services for the Handicapped - Frederick & Washington Counties
   -- Home Care Services for the Handicapped - Allegany & Garrett Counties
2. United Cerebral Palsy of Central Maryland Respite Care Program
   -- Colton Manor Respite Care
3. Victor Cullen Center Respite Care
4. Western Maryland I Mental Retardation Center - Hagerstown
5. Western Maryland II Mental Retardation Center - Cumberland

VII. FACILITIES

Recommendations relative to the design and modification of facilities for the low incidence handicapped are contained here. Specific guidelines will be distributed by the Maryland State Department of Education at the completion of a research project on facilities guidelines being conducted by the Division of Special Education and the Education Section of the Interagency Committee on School Construction.

A. Location

The location of the facility should be determined according to compliance with the major tenets of P.L. 94-142 listed here in priority order.

1. Delivery of the program stipulated in the child's IEP.
2. As much contact as is feasible with nonhandicapped peers.

It is suggested that the location of programs for children with low incidence handicapping conditions ought to be selected using the following guidelines:

1. This group of children should be included in classes with other children who are less handicapped. This is beneficial to both children and staff. As explained under Section F, Placement, no center should be designed to serve only the low incidence handicapped.
2. With respect to the development of a new structure, a wing added to a general education building is preferred to a separate center.
3. The economic aspects of "clustering" must be weighed against the requirement for the provision of services in the least restrictive environment.

B. Building Design

1. Structure

a. A basic point to consider is a one-story design. Elevators simply do not correct the inconvenience and inefficiency of a multi-story structure. However, where a multi-story facility must be used, it is possible to redesign the first floor to accommodate those children with mobility problems. Access to services must not be limited by this procedure.

b. Wheelchair accesses - Every entrance and exit must be wheelchair accessible. This is especially critical relative to fire exits.

c. Curb cuts - When possible, no curbs should exist. If this is not possible, curb cuts should be directly adjacent to each entrance.

d. Covered areas for boarding and deboarding - There must be, at minimum, an awning that extends the length of the building so that many buses can load and unload simultaneously. A great deal of instructional time is lost while children wait to be dropped off and picked up.

2. Access to Services and Meeting Areas

Services which require some outside classroom base, such as OT, PT, or Speech, should be close to the classrooms. Meeting areas near classrooms should be provided so that teachers can attend daytime conferences and meetings near their students. A workroom for adaptation and construction of equipment is extremely useful.

3. Food Preparation

It is most efficient if meals for this population can be prepared or at least modified within the school building. This is recommended so that foods served can reinforce curriculum objectives associated with eating. This requires an especially equipped area for this function. (Specifics on equipment are found under that section on page 56.)

4. Eating Areas

a. The option of serving meals in the classroom must be available. The area used should be uncarpeted.

b. Space must be available in the school lunchroom or cafeteria in which children with low incidence handicaps can have lunch.

5. Personal Care Areas

Areas in which children are provided with personal care and in which materials can be stored are essential.

6. A refrigerated storage area such as a small icebox must be located with easy access to classrooms so that food for lunch programs conducted in the classroom can be obtained quickly. This prevents considerable loss of staff time which may result when all food is kept in a central area.

7. One shower and bathtub room should be provided for and be near each group of five classrooms.

8. Vocational Education Areas

Since the facility used for the low incidence handicapped may be expected to also serve the moderately handicapped, it

should contain areas for vocational education including home living. These areas may be constructed as they are in recently-built special centers. Accommodation must be made for children with sensory impairments and gross and fine motor difficulties.

9. Safety

Considerations include:

-- patterns for egress in the event of fire.

-- a signal system relative to necessary evacuation which does not cause a startle reaction and which has a visual component for deaf students.

-- multiple exits from the building, all of which are wheelchair accessible.

-- absence of deadend hallways.

-- nonskid tile.

-- railings in all toilet stalls.

-- elimination of sharp corners and edges such as may be found on chalk trays and ventilators. In renovated buildings, padded tape may be used.

-- break-resistant windows are extremely desirable. Multiple panes in classroom doors should be avoided.

-- recessed doorways. Doors must open out from the classrooms as mandated by fire regulations. Recessed doorways reduce the degree to which the door extends into the corridor.

10. Color

It is suggested that soft shades of various colors be used to allow for more flexibility in the design of instructional displays and decorations.

11. Floors

a. Carpeting must be low-pile, wear-resistant, and easily cleaned. The cost of material, equipment, and labor for maintaining and cleaning the carpeting must be recognized.

b. Wet areas must be covered with non-slip, easily maintained material.

c. No area rugs or runners should be used because they are obstacles for children who have difficulty walking or for those in wheelchairs.

d. Every classroom should have a wet area. One-third should be floored with a dense, resilient material, such as vinyl asbestos (not terrazo or ceramic tile), which is resistant to toileting accidents, foodspills, etc.

12. Lighting

a. Accommodations must be made for children with visual impairments with devices such as rheostats.

b. Fluorescent lights may glare into the eyes of children who lie on mats and look up. Such light should be diffused in order to avoid this problem, if the use of non-fluorescent lights is not practical.

c. Fluorescent bulbs must be adequately covered for safety.

13. Hardware

a. Handrailings should be provided on both sides of all toilet stalls and on both sides of all hallways.

b. Doorhandles must be provided which respond to downward pressure. Knobs are unacceptable because they are too difficult to manage for many of the children who will be served in a facility for the low incidence handicapped.

14. Sound

Carpeting helps a great deal in reducing noise. Accoustical ceiling tiles should be used in all student areas.

15. Sound Systems

a. Each building must be equipped with a communication system that includes a public address component which reaches the total building and the bus parking area. A call-back light (or buzzer, where necessary) is desirable to avoid classroom disruptions. There must be a microphone for the PA system that persons in the outside area, such as drivers and aides, can use in communicating with inside staff. This will allow staff to identify absent children, misplaced children, forgotten medication, crutches, etc. These systems not only save time, but reduce the possibility that children will be left unattended.

b. The communication system must be capable of two-way exchanges between the central office and each classroom.

C. Classroom Design

1. Size

The space provided must allow for children on mats and in wheelchairs, a place for the delivery of OT and PT, and individual and group instructional areas. It is estimated that the room should be roughly the same size as one designed for 20-25 kindergarten children -- that is, 1,100 square feet. Storage and toileting areas which are necessary for each classroom are calculated in addition to this estimate.

2. Activities which should be accommodated in every classroom include:

-- timeout

-- toileting and diapering

-- therapy area

-- observation

-- assessment

-- feeding

-- teacher planning

3. Major fixtures include mounted mirrors, chalkboards, and bulletin boards.

4. Storage

Materials to be stored include instructional materials, personal hygiene materials, curriculum materials, and clothing. There must be locked storage cabinets and shelves to which teachers have convenient access. Overhead shelves may be an advantage. Some storage in an adjacent, lockable room should be provided for valuable items or those used infrequently. Sharing

a storage room between classrooms should be considered to facilitate storage of large and/or special equipment which may be shared.

5. Woodworking areas

It is extremely useful for OTs and PTs and in some instances teachers to have access to a workshop where wood, hardware, and tools are available for the adaptation or construction of equipment. Often volunteer organizations also provide assistance in construction. If the program serves the moderately handicapped, the workshop used in their program should be made available to OTs and PTs and teachers at specifically arranged times. In the absence of a workshop, some alternative should be arranged.

6. Plumbing

a. Toilets, sinks, and bathing facilities must include those designed for wheelchair students. Some sinks in each facility must be designed so that they are accessible for students in child-sized wheelchairs. Sinks designed to accommodate standard-sized wheelchairs are too high for primary and elementary school-aged children.

b. Faucets in sinks should have six to eight-inch handles which can be pushed. Knobs are unacceptable. Faucets from which water cuts off automatically are unacceptable. Water should come from one spigot, but should deliver either hot or cold or a mixture. All faucets should be

equipped with a cutoff and an alarm system to regulate use of hot water by children.

c. It is recommended that the toilets purchased be the type designed for homes. It is particularly important that the seat itself is a closed circle or oval. Adaptations for use of toilets by small children should be purchased.

d. At least some bathtubs should be available which are mounted on platforms three feet above floor level. This arrangements makes lifting and bathing of children considerably easier for the staff.

7. Cleanliness

a. Provision must be made for the hygienic disposal of waste. Laundry facilities must be available near the classroom.

b. The administration must clearly delineate and enforce all aspects of cleaning, including disposal of diapers, cleaning of floors, mats, clothes, bibs, emptying of wastecans, etc.

VIII. EQUIPMENT

This section lists equipment items judged to be necessary for effective operation of the program and their estimated costs as of fall, 1978. Where products can be built rather than purchased from commercial producers, considerable expense will be avoided. Obviously, equipment costs are greatest at the opening of a program.

The list on the following page is not all-inclusive. The presenting problems of individual children will dictate unique equipment needs for each school. Items cited here will initially fill the basic requirements of most of the students.

Equipment	Unit Cost	Amount Needed	Total for 7:1 Ratio, 15 Classes
Incline mats	$145.40	3/class	$6543.00
4'x6' mats	125.85	5/class	9438.75
Bobath balls	37.00	1/class	555.00
Beanbag chairs	41.00	2/class	1230.00
Hospital screens	89.00	1/class	1335.00
Straightback chairs	15.95	100/bldg	1595.00
Rollators	69.00	2/class	2070.00
Walkers (all sizes)	68.20	100/bldg	6820.00
Proneboards	395.00	5/bldg	1975.00
Tilt tables	598.00	5/bldg	2990.00
Wheelchairs (jr.)	265.70	2/bldg	531.40
Wheelchairs (adult)	360.00	2/bldg	720.00
Bolsters	77.30	5/class	5797.50
Hip control bench	96.50	1/class	1447.50
Auto tires	donated		—
Stabilizers	95.00	1/class	1425.00
Commode chairs	92.00	1/class	1380.00
Standing tables	137.15	5/bldg	685.75
Vibrating mats	25.00	3/class	1125.00
Washer-dryer	465.00	1/bldg	465.00
Workbench	49.99	2/bldg	99.98
Radial-arm saw	389.99	1/bldg	389.99
Airomats (5x6x16)	480.00	1/bldg	480.00
Mounted Paral. bars	598.50	1/bldg	598.50
Changing tables	49.00	1/class	735.00
Playground equip.	365.00	1/bldg	365.00
Trike (child size)	120.00	10/bldg	1200.00
Trike (adult size)	120.00	10/bldg	1200.00
Exercise bikes	139.00	1/bldg	139.00
Body supports	29.95	10/bldg	299.50
Toolbox & tools	69.99	1/bldg	69.99
Tri-Wall	200.00		200.00
Airomats (10x10x16)	650.00	1/bldg	650.00
Total Equipment			$54,555,86

IX. MATERIALS

Materials recommended in the charts following are grouped as follows: reference books and inservice materials, assessment instruments, instructional materials -- both those used directly by the teachers and those by students, food service supplies, and materials for the personal care of students.

Cost estimates are included to illustrate the amount of funds needed for these supplies, many of which are consumable.

TEXTS AND ASSESSMENT INSTRUMENTS

Description	Unit Cost	Amount Needed	Total for 7:1 Ratio, 15 Classes
Basic texts:			
Handling the Young Cerebral Palsied Child - N. Finney	$ 7.00	1/teacher	$105.00
Changing Children's Behavior - Krumboltz and Krumboltz	9.00	1/teacher	135.00
Educational Programming for the Severely and Profoundly Handicapped - Sontag	10.00	1/bldg	10.00
Physically Handicapped Children: A Medical Atlas for Teachers - Bleck & Nagel	30.00	1/bldg	30.00
Sign Language Text	5.00	3/bldg	15.00
The Right-to-Education Child - Myers, Sinco & Stalma	8.00	1/teacher	120.00
Text on Sexual Development	15.00	1/bldg	15.00
Nonvocal Communication Techniques & Aids for the Severely Physically Handicapped - Vanderheiden & Grilley	13.00	1/bldg.	13.00
Systematic Instruction of the Moderately and Severely Handicapped - Snell	20.00	1/bldg	20.00

Description	Unit Cost	Amount Needed	Total for 7:1 Ratio, 15 Classes
Texts, cont'd:			
Functional Aids for the Multiply Handicapped - Robinault	$16.00	1/bldg	$ 16.00
Primitive Reflex Profile - Capute	13.00	1/bldg	13.00
Mental Retardation Syndromes	8.00	1/bldg	0
Developing Effective Individualized Education Programs for Severely Handicapped Children and Youth - Haring	10.00	1/bldg	10.00
Toilet Training the Retarded - Foxx & Azrin	5.00	3/bldg	15.00
Educating the Severely and Profoundly Retarded - Anderson & Greer	10.00	1/bldg	10.00
Mealtimes for the Severely and Profoundly Handicapped - Perske	8.00	1/bldg	8.00
Assessment:			
TARC -Topeka Assn. for Retarded Citizens	7.30	2/bldg	14.60
BCP -Vort Corp.	21.35	2/bldg	42.70
Denver Scale	6.25	2/bldg	12.50
Millani-Comparetti	13.00	2/bldg	26.00
Infant Learning Accomplishments Profile	2.00	2/bldg	4.00
Uzirgis-Hunt	10.00	2/bldg	20.00

Description	Unit Cost	Amount Needed	Total for 7:1 Ratio, 15 Classes
Callier-Azusa	$ 3.25	2/bldg	$ 6.50
Receptive and Expressive Emergent Language Scale	9.75	2/bldg	19.50
Pinpoint Scanning Device		5/bldg	
Total Texts and Assessment			$688.80

Teachers' Instructional Materials:

Stopwatch	$ 50.50	1/teacher	$757.50
Kitchen timer	25.35	1/teacher	380.25
Clipboard	.85	1/teacher	12.75
Tagboard (12x16)	3.35	1/teacher	50.25
Velcro (25 yd)	20.25	1/bldg	20.25
Plastic sheets (8½x11)	5.75/carton	1/teacher	86.25
Plan sheets Data sheets) Charts	25.00	1 set/teacher	375.00
BlysSymbolics Kit	41.00	1/class	615.00
Sound sensitive light	29.95	1/class	449.25
Record Player	99.95	1/class	1499.25
Tape recorder	94.95	1/class	1424.25
Electronic communication device	298.60	1/bldg	298.60
Listening center	62.95	1/class	944.25
Total Teacher's Materials			$6912.85

Description	Unit Cost	Amount Needed	Total for 7:1 Ratio, 15 Classes
Children's Materials:			
Consumable rewards	$ 1.89	10/teacher	$283.50
Contact paper (1 yd)	.89	50 yd./bldg	44.50
Sponge rubber	200.00		200.00
Vinyl	100.00		100.00
Plywood	300.00		300.00
Plexiglass	100.00		100.00
Dowel sticks	15.00		15.00
Vibrators	6.26	10/bldg	62.60
Sheets	Donated		
Hangers	Donated		
Baggies	10.00		10.00
Resonator bells	189.70	2 sets/bldg	379.40
Flashlights	.79	20/bldg	15.80
Penlights	.49	20/bldg	9.80
Sponges	1.00	25/bldg	25.00
Hand mirrors	18.65	20/bldg	373.00
Table mirrors	25.00	16/bldg	400.00
Hand-sized noise makers -- teacher-made			
Knobbed puzzles (set)	95.45	5/bldg	477.25
Mobiles	2.98	3/class	134.10
Clutch balls	20.25/dozen	3/bldg	60.75
Towels	Donated		
Total Children's Materials			$2990.70
Food Service Supplies:			
Nonskid trays	$ 40.26/set	10/bldg	$ 402.60
Swivel spoons	2.00	50/bldg	100.00
Dishes (rimmed)	121.55/doz.	4/bldg	486.20
Cut-out cups	1.00/doz.	4 doz/bldg	48.00
Scoop dishes	3.49	4 doz/bldg	167.52
Spoons	28.05/doz.	10/bldg	280.50
Forks	28.05/doz.	10/bldg	280.50
Knives	38.05/doz.	10/bldg	380.50
Snorkel cups	35.30/doz.	4/bldg	141.20
Partitioned dishes	1.85/	4 doz/bldg	88.80
Partitioned trays	1.49	90/bldg	134.10
Rubber squeeze bottles	.85	12/bldg	10.20
Disposable bibs	4.50/pack	20/bldg	90.00
Total Food Service Supplies			$2610.12

Description	Unit Cost	Amount Needed	Total for 7:1 Ratio, 15 Classes
Personal Care Materials:			
Baby powder	$ 50.00		$ 50.00
Baby lotion	50.00		50.00
Disposable diap.	32.99/360s	3/bldg	98.97
Kotex	27.48/case	1/bldg	27.48
Vaseline	16.68/case	1/bldg	16.68
Desitin	18.48/case	1/bldg	18.48
Rubber gloves	1.49/pr	5/teacher	111.75
Diaper pins	1.45/gross	12/bldg	17.40
Training pants	6.10/6	54/bldg	54.90
Alcohol	.29	10/bldg	2.90
Bandaids	1.75	1/class	26.25
Combs	.29	125/bldg	36.25
Brushes	1.15	125/bldg	143.75
Soap	1.00/3 bars	3/class	15.00
Toothbrushes	.33	125/bldg	41.25
Toothpaste	.49	1/child	49.00
Green bags	4.19/40	1/class	62.85
Total Personal Care Materials			$822.91

Texts-Assessment	$ 688.80
Teacher's Instructional	6912.85
Children's Instructional	2990.70
Food Service Supplies	2610.12
Personal Care	822.91
Total, All Materials	$14025.38

X. TRANSPORTATION

A. Legal Requirements

Federal law (P.L. 94-142) requires that transportation be provided for all children who receive special education. The Maryland State law and Special Education Bylaw mandate transportation of school children to special education and to related services as stipulated in the child's IEP.

B. Vehicle Design

Buses should be designed with safety as a primary consideration. Provisions for the strapping of wheelchairs to the sides of the bus are critical. Specific locations for crutches, walkers, folded wheelchairs, etc. should be clearly identifiable. Lifts must have high sides for safety and reduction of fear in the passengers. If power controls are used, manual operation must be an option. The lift mechanism must be protected from freezing in cold weather. All buses for these handicapped students should have some type of two-way communication system. Window sills on buses should be padded to prevent injury to children's heads, mouths, and chins.

C. Child Management

The Division of Special Education has published a manual for bus drivers on the management of handicapped children. The essential points to be considered include the following:

1. The school administration must establish a simple and workable system of matching children with buses so that a minimum of time is spent by children and drivers waiting for each other. In the absence of such a system, much instructional time is lost, and unnecessary time is spent by children on the bus.

2. An adequate number of aides must be on each bus.

3. Children with behavior problems should be placed near aides.

4. At least one adult on each bus must be prepared to deal with seizures.

D. Emergencies

1. Bus drivers and aides must be informed of any anticipated difficulties that the children might have, such as seizures, asthmatic attacks, projectile vomiting, etc.

2. Each bus team must have a plan for dealing with a variety of emergencies including:

   a. direct treatment if appropriate

   b. who will seek help, who will attend to the child in crisis, how will the other children be managed, how to contact parents, hospitals, police, etc.

3. Each bus should be equipped with Vo-ban or some other compound for temporary immediate treatment of vomitus, excrement, etc.

XI. FUNDING

An estimated breakdown of total funding costs for a low incidence handicapped children's facility follows. This is based on funding for a center serving approximately 100 students at a child-to-staff ratio of 7:1, as of January, 1979. Cost details for equipment, furniture, and materials are listed in Sections VIII and IX. Overall costs are reduced when programs are designed to serve the low incidence handicapped in combination with children with moderate impairments.

School construction and transportation are paid out of separate funding. Costs are met with State, local, and federal funds. An analysis of the FY '79 Special Education budget discloses the breakdown which follows:

Basic Cost:	State	6.20%	
	Local	16.75	
			22.95%
Excess Cost:	Federal	3.86	
	State	38.69	
	Local	34.50	
			77.05
			100.%

Staff salaries are derived from Statewide average costs. Plant operation, plant maintenance, and fixed charges are based on FY '77 per pupil costs for each of these areas.

Description	Unit Cost	Number Needed	Total for 7:1 Ratio, 15 Classes
Staff Needs:			
Spec. Ed. teacher	$13948	1/class	$209,220.00
Spec. Ec. aide	5449	1/class	81,735.00
OT	15075	1¼/school	18,844.00
PT	14426	1¼/school	18,033.00
S/L teacher	14120	1¼/school	17,650.00
Psychologist	18600	1/school	18,600.00
Principal	25096	1/school	25,096.00
Vice-principal	20090	1/school	20,090.00
Secretary	7805	2/school	15,610.00
Therapy aides	5000	2/school	10,000.00
Total Staff			$434,878.00

Overhead Costs:

Operation of Plant	$16,982
Plant Maintenance	5,741
Fixed Charges	8,301
	$31,024.00

The following totals for equipment (page 56), materials (page 62), staff (above), and overhead costs (above) yield the approximate cost per child in a facility serving 100 children at a 7:1 ratio:

Equipment	$ 54,555.86	
Materials	14,025.38	
Staff	434,878.00	
Overhead	31,024.00	
Total	$ 534,483.24	divided by 100 = $5345/child

XII. BIBLIOGRAPHY

An Atlas of Mental Retardation Syndromes, Government Printing Office, Washington, D.C.

Balthazar, E.E., Training the Retarded at Home or in School, Palo Alto, Consulting Psychologists Press, 1976.

Bergen, A., Selected Equipment for Pediatric Rehabilitation, Valhalla, N.Y., Blythedale Children's Hospital, 1977.

Bigge, J., Teaching Individuals with Physical and Multiple Disabilities, Columbus, Charles E. Merrill Publishing Co., 1976.

Bleck, E.E. and Nagel, D.A., Physically Handicapped Children: A Medical Atlas for Teachers, New York, Greene and Stratton, 1975.

Buttram, B. and Brown, G., Developmental Physical Management for the Multi-disabled Child, Tuscaloosa, U. of Alabama, Area of Special Education.

Bzoch, Assessing Language Skills in Infancy, Baltimore, University Park Press.

Capute, A., Primitive Reflex Profile, Baltimore, University Park Press.

Crickmay, M.C., Speech Therapy and the Bobath Approach to Cerebral Palsy, Springfield, Ill., Charles C. Thomas, 1975.

Education Service Center, Secrets for Survival, The Training Program for Teachers of the Severely/Profoundly Handicapped, Region XIII, Austin IX, 1977.

Finnie, N.R., Handling the Young Cerebral Palsied Child at Home, New York, E.P. Dutton, 1975.

Foxx, R. and Azrin, N., Toilet Training the Retarded, Champaign, Ill., Research Press, 1973.

Haring, N.G. (ed.), Developing Effective Individualized Education Programs for Severely Handicapped Children and Youth, Department of Health, Education and Welfare, Office of Education, Bureau of Education for the Handicapped, 1977.

Haring, N.G., Behavior of Exceptional Children: An Introduction to Special Education, Columbia, Charles Merrill Co., 1974.

Henderson, S., and McDonald, M., Step-by-step Dressing, Bellevue, Wash., Edmark Associates.

Johnson, V.M. and Werner, R.A., A Step-by-step Learning Guide for Retarded Infants and Children, Syracuse, Syracuse University Press, 1975.

Kamenetz, H. L., The Wheelchair Book, Springfield, Ill, Charles C. Thomas, 1969.

Kent, L., Language Acquisition Program for the Severely Retarded, Champaign, Ill., Research Press, 1974.

Krumboltz, L.D. and Krumboltz, H.B.,Changing Children's Behavior, Englewood Cliffs, N.J., Prentice-Hall, 1972.

Melton Book Co., The Radea Program, Dallas, Melton Book Co.

Myers, Donald, Sinco, Michael, Stalma, Ellen, The Right to Education Child, Springfield, Ill., Thomas, 1973.

Pearson, P. and Williams, C. (eds.), Physical Therapy Services in the Developmental Disabilities, Springfield, Ill., Charles C. Thomas, 1972.

Perske, Robert, Clifton, Andrew, McClean, Barbara, and Isler Stein, Jean (eds.),Mealtimes for the Severely and Profoundly Handicapped Persons: New Concepts and Attitudes, Baltimore, University Park Press, 1977.

Robinault, T. (ed.), Functional Aids for the Multiply Handicapped, New York, Harper and Row, 1973.

Sailor, W. and Mix, B.T., The TARC Assessment System, Lawrence, Kans., H. & H. Enterprises, 1975.

Schiefelbusch, R.L., and Lloyd, L.L., Language Perspectives -- Acquisition, Retardation, and Language Intervention, Baltimore, University Park Press, 1974.

Snell, Martha (ed.), Systematic Instruction of the Moderately and Severely Handicapped, Columbus, Charles E. Merrill Publishing Co., 1978.

Sontag, E. (ed.), Educational Programming for the Severely and Profoundly Handicapped, Reston, Va., Division of Mental Retardation, The Council for Exceptional Children, 1977.

Tawney, T. W., Telecommunications for the Severely Handicapped, Department of Health, Education, and Welfare, Office of Education, 1977.

Thomas, M.A. (ed.), Hey, Don't Forget About Me!, Reston, Va., The Council for Exceptional Children, 1976.

Turner, K. and Fair, E. Somerton, The Pennsylvania Training Model, Pennsylvania Department of Education, Bureau of Special and Compensatory Education, Division of Special Education, 1976.

Vanderheiden, G.C. and Grilley, K. (eds.), Non-vocal Communication Techniques and Aids for the Severely Physically Handicapped, Baltimore, University Park Press, 1976.

Wolf, T.M. and Anderson, R.M, The Multiply Handicapped Child, Springfield, Ill., Charles C. Thomas, 1969.

Wolf, T.M., The Results of Treatment in Cerebral Palsy, Springfield, Ill., Charles C. Thomas, 1969.

Testing Instruments:

Assessment of Deaf-Blind Children: the Callier-Azuza Scale, developed by Robert D. Stillman, available through the Council for Exceptional Children, Reston, Va. 1976.

The Developmental Pinpoint Scanning Device, Cohen, Marilyn and Goss, Pamela.

The Learning Accomplishment Profile, prepared by Anne Sanford (ed.), Chapel Hill Training-Outreach Project 1974, published by Kaplan Press, Winston-Salem, 1976.

The Topeka Association for Retarded Citizens Test (TARC), copyright by H & H Enterprises, Inc., Lawrence, Kans., 1975.

APPENDICES

A. Sample interview form -- University of Vermont Center for Special Education.

B. Access to training -- the Comprehensive System of Personnel Development.

C. Description of Maryland's Direction Centers.

D. State Association for Retarded Citizens Chapters.

E. Information on Respite Programs.

F. Information on the Maryland Deaf/Blind Project.

G. A Summary of Parental Rights and Responsibilities -- State Level Hearings.

H. Surrogate Parent Guidelines.

I. A list of State Department publications which are referred to in this manual.

APPENDIX A

Interview Information

Center for Special Education
University of Vermont

Interviewer: _____

Date: _____

1.0 Indentifying Date

1.1 Name:

1.2 Birthplace: Hospital:

1.3 Birthdate:

1.4 Resides With:

Address:

Telephone:

Relationship:

School District:

1.5 Parents:

Address:

Telephone:

School District:

2.0 Background Information

2.1 Past Residences:

2.2 Local Physician (Primary Care):

Address

Telephone:

2.3 Has Been Seen by Other Physicians:

2.4 Has Received Medical Services From:

2.5 Has Undergone Medical Evaluations at (Hospitals, Clinics):

2.6 Dates of Relevant Physical and Other Examinations:

Medical:

Neurological:

Vision:

Hearing:

OT/PT:

Speech Pathologist/Therapist:

Dentist:

Other:

-

-

-

2.7 Medications

Who Prescribed:

Given by whom:

When - time taken and dosage if known:

2.8 Health/Physical Problems:

2.8.1 Frequent Colds:

2.8.2 Appetite (amount and type of food):

2.8.3 Childhood Diseases:

2.8.4 Operations:

2.8.5 Seizure Disorder:

Description:

Physician:

Medications:

2.8.6 Suspected Sensory Impairments:

2.8.7 What specific medical or physical problems are you aware of?:

2.9 Previous Services:

2.9.1 Educational:

2.9.2 Physical Therapy:

2.9.3 Speech and Language:

3.0 Where is the child generally?: (On the floor, in bed, in a wheelchair, etc.)

3.1 Does the child have any equipment or apparatus that helps him sit, walk or eat?

3.2 What are your major concerns for the child?

4.0 Communication

4.1 Indicators of potential interdisciplinary team involvement. If any are no, consult I-Team.

	Structure	Yes	No	Function	Yes	No
4.1.1	Jaw Remains in midline (at rest)			Remains in midline during movement. Opens and closes easily.		
4.1.2	Lips a) Remain symmetrical (at rest)			Remain symmetrical during movement		
	b) No bilateral or repaired unilateral cleft or residual scar			Can pucker lips Can show teeth		
4.1.3	Teeth a) None missing, extra, or tilted b) Does not have malocclusion c) Do not appear discolored					
4.1.4	Tongue a) Lying on bottom of mouth			Can protrude and retract		
	b) No tremor-like movement at rest			Can elevate and depress tongue. Can wiggle tongue from side to side 3-5 times per second		
4.1.5	Palate No cleft palate			Does not sound hypernasal		
	No repaired palate			Does not sound hypernasal		
4.1.6	Larynx			Voice is not hoarse		
				Does not have strained, strangled voice quality		
				Tone production is not broken or interrupted		

	Structure	Yes	No	Function	Yes	No
4.1.7	Breathing - # of breaths per minute is less than 25			Thorax - shoulders do not elevate during inhalation		
				Abdomen does not retract during inhalation		
4.1.8	Eyes No nystagmus (rapid movement of eyes from side to side) No strabismus (crossed eyes) No apparent vision problems					

4.2 Pupil Communication Skills	Yes	No

4.2.1 Speech

Expressive

Uses real words to obtain wants and needs (21 mo.) List examples.

Combines 2-3 words to make a sentence, such as "play blocks" (24 mo,) List examples.

Refers to self by name (24 mo.)

Names objects or pictures
Specify: 1._____ (18 mo.)

2._____

3._____

4._____

5._____

6._____

7._____

8._____ (24 mo.)

Receptive

Responds to own name by stopping activity (3 mo.)

Can follow verbal directions, such as:

come here
stand up
no
give me (15 mo.) List examples.

Recognizes and identifies almost all common objects and pictures of common objects when they are named (20 mo.)

Can follow two simple related directions, such as "Get book, open it." (21 mo.) List examples.

	Yes	No
4.2.2 Non-Speech		
Expressive		
Indicates comfort, such as tired, sick, hot, cold, uncomfortable position (4 mo.) List examples.		
Expresses affect, such as sad, interested, surprised, afraid, frustrated (7 mo.) List examples.		
Indicates wants and needs through gestures (12 mo.) List examples.		
Receptive		
Understands caregiver gestures List examples.		
5.0 Motor		
5.1 Indicators for I-Team Involvement If any are yes, consult I-Team		
5.1.1 Does child have known physical anomalies?		
For example:		
Spina bifida		
Dislocated hips		
Foot problems		
Cerebral Palsy		
Other		
5.1.2 When sitting or standing, is child's back in good (usual) position for age?		
Looking from back:		
Are shoulders, spine, hips nonsymmetrical?		
Looking straight from side:		
Does child slump forward? (Not unusual under 1 year in sitting)		
Does child have "sway back"?		

	Yes	No
5.1.3 Does child have difficulty moving body parts?		
One arm and leg more than the other		
Legs more than arms		
Any one limb or joint (Specify - for example - does not wiggle toes on one foot)		
5.1.4 Does child move body parts but have difficulty controlling the motion?		
arms and hands		
legs		
head		
total		
5.1.5 Does child have any joints which do not move freely when moved by another person?		
Examples are:		
On back rigidly extended (hard to pick up or cuddle)		
On back with legs crossed (or scissored)		
On back with legs drawn up and to sides (frog-leg)		
On back in "fencer position"		
5.1.6 Is child unable to change his position even when uncomfortable?		
5.2 Pupil Functioning Level		
Has head control (3 mo.)		
How long?		
What position?		
Reaches for object with two hands (5 mo.)		
Reaches for object with one hand (10 mo.)		
Grasps one block in palm of hand (6 mo.)		

	Yes	No
Transfers objects hand to hand (7 mo.)		
Rolls over both ways (6mo.)		
Sits unsupported on hands (7 mo.)		
Sits unsupported (9 mo.)		
Creeps/crawls (9 mo.)		
Stands supported (9 mo.)		
Stands unsupported (15 mo.)		
Walks supported (12 mo.)		
Walks unsupported (15 mo.)		
Climbs stairs		
One foot per tread (42 mo.)		
Two feet per tread (24 mo.)		
Jumps down from low step (24 mo.)		
Throws ball (18 mo.)		
Uses pedal vehicles (24 mo.)		
6.0 Self-Care		
6.1 Indicators of potential interdisciplinary team needs. If any are yes, consult I-Team		
6.1.1 Eating		
Exhibits:		
Gag reaction		
Bite reaction		
Tongue thrust		
Profuse drooling		
Inability to bring hand to mouth		
Does the pupil not eat:		
Liquids (0 mo.)		

	Yes	No
Semi-solid foods (3-6 mo.)		
Chopped foods (9-12 mo.)		
Usual foods (12-18 mo.)		
6.1.2 Toileting (If yes, consult I-Team)		
Is constantly wet?		
Unusual consistency or odor to urine or stool?		
Has a long-term history of failure to toilet train?		
6.2 Functioning Level		
6.2.1 Eating		
1. Time required to eat, and neatness		
2. Needs to be fed (0-18 mo.)		
3. Drinks liquids (1 mo.) Swallows?		
4. Drinks from a bottle (0-12 mo.)		
5. Eat strained food (0-3 mo.)		
6. Visually track food and eating utensils (3 mo.)		
7. Eat semi-solid foods (3-6 mo.)		
8. Chew well (6-9 mo.)		
9. Put finger food in mouth (6-9 mo.)		
10. Eat solid foods (9-12 mo.)		
11. Use spoon assisted (9-18 mo.)		
12. Eat pieces of meat (12-18 mo.)		
13. Drink from cup held with two hands (12-18 mo.)		
14. Drink from cup held with one hand (18-24 mo.)		
15. Use spoon unassisted (18-24 mo.)		

	Yes	No
16. Use fork (48-60 mo.)		
17. Cut with knife (48-60 mo.)		
6.2.2 Toileting		
1. Is diapered		
2. Indicates when wet (12-18 mo.)		
3. Indicates need to go (24 mo.)		
4. Has occasional accidents		
5. Toilets on schedule (24-30 mo.)		
6. Is dry during day (24-29 mo.)		
7. Toilets independently (48 mo.)		
8. Is dry through night (48-60 mo.)		
6.2.3 Personal Hygiene		
Pupil:		
Shaves body hair		
Combs/brushes hair (48 mo.)		
Keeps nose clean (48 mo.)		
Bathes (48-72 mo.)		
Washes hands (48 mo.)		
Washes face (48 mo.)		
Menstruates		
Cares for own menstruation		
6.2.4 Dressing and Undressing		
1. Assists caregiver in dressing (12 mo.)		
2. Takes off hat, socks, mittens (18 mo.)		
3. Puts on hat, socks, mittens (24 mo.)		

	Yes	No
4. Takes off shoes (24 mo.)		
5. Unzips (24-29 mo.)		
6. Takes off pants (30 mo.)		
7. Dresses with supervision (36 mo.)		
8. Pulls shoes on (36-48 mo.)		
9. Unbuttons buttons (36-48 mo.)		
10. Laces shoes (48-60 mo.)		
11. Dresses independently (60-72 mo.)		
12. Ties shoe lace (72 mo.)		
7.0 Social		
7.1 Inappropriate Behaviors		
Isolates self from others		
Hurts self		
Hurts others		
Tantrums		
Runs away		
Stereotyped behaviors		
Fearful of people		
7.2 Pupil Functioning Level		
Follows moving person with eyes (1 mo.)		
Smiles socially at people (4 mo.)		
Initiates contact by smiling or making sounds (5 mo.)		
Actively watches adult from across the room (5 mo.)		
Will play by self for 15-30 minutes (7 mo.)		
Cooperates in social games e.g., waves bye-bye, plays pat-a-cake (10 mo.)		

	Yes	No
Waves bye-bye appropriately without imitation (12 mo.)		
Enjoys putting in and taking out games (12 mo.)		
Indicates wants by pointing or vocalizing (15 mo.)		
Hugs and gives pleasure to parents (15 mo.)		
Defends self when taken advantage of (18 mo.)		
Sometimes says "No" when interfered with (18 mo.)		
Pulls adult to show or help (21 mo.)		
Engages in fantasy play with doll (24 mo.)		
Tries to help and comfort others (24 mo.)		
Parallel play - does same thing as another child (24 mo.)		
Makes believe involving household tasks (24 mo.)		
Greets adults (30 mo.)		
Helps put things away (30 mo.)		
Shares and trades (36 mo.)		
Takes turns (36 mo.)		
Engages in cooperative play with 2-3 other children (42 mo.)		
Knows which toys are his and which belong to others (48 mo.)		
Role plays - family roles (48 mo.)		

APPENDIX B

ACCESS TO TRAINING

The Division of Special Education will provide assistance to LEA personnel, as well as those in State operated and nonpublic facilities in the development and implementation of inservice training. Agencies wishing to obtain assistance for personnel providing services to handicapped children are asked to review Section Four of this manual, "Training Areas," to see the direction this Division's training efforts will take, as well as to use the suggested delivery strategies. These strategies, of course, are merely recommendations and are not intended to preclude the development of other strategies which may be more appropriate for individual needs. (All agencies who are interested should utilize the Training Request Form, a copy of which is contained on page 13 of this section of the manual.) The steps involved in utilizing this Form are outlined below:

Training Request Form

1. Where the form requires, supply the name of the individual to be contacted for planning.

2. The local director of special education must sign all requests for training.

3. Identify the area in which training is desired. Refer to one of the ten training areas outlined in Section Four.

4. Identify the objective or objectives to be achieved during the training. Please be specific.

5. Describe the strategy most suited to the purpose of the training. (Strategies are not limited to those listed in the Manual.)

6. Describe the participants in the proposed training.

7. Specify the timeframe, dates and alternate dates for the training. (With the exception of short-term training which can be delivered by inhouse staff, it is essential that MSDE personnel have sufficient lead time to assist in appropriate planning. Therefore, we are requesting a minimum of six weeks between the date on which the Program Development and Assistance Branch receives the Training Request Form and the anticipated initial date for beginning training.

8. Identify the site where the training is to take place. Supply information on any specific arrangements which must be made for the use of the site and indicate whether these arrangements are to be made by the requestor or by the Division.

9. Provide additional information that will assist in planning the training including the need for substitutes, special procedures for release time, and equipment or materials. The following restrictions apply, either because of federal or state regulations:

   a. The maximum allowable stipend reimbursement is $15 per day.
   b. The maximum allowable consultant remuneration is $100 per day.
   c. The maximum allowable substitute reimbursement is $25 per day.
   d. The maximum allowable cost per individual training request is $3,000.

10. Because we will be expanding our efforts for this coming year, and because we have not received an increase on funding, Maryland State Department of Education, Division of Special Education, can no longer assume <u>total</u> financial costs for the provision of inservice training. Please be certain that for Item 9 on the Training Request Form (page), there is a breakdown of both local <u>In-kind Contributions</u> as well as those costs for which the Maryland State Department of Education funds are requested. By way of example, In-kind Contributions could include any of the following: (1) provision of space or equipment; (2) costs for duplicating or disseminating information or materials; (3) costs for substitutes or stipends, or costs provided for substitutes or stipends beyond the maximum allowable amounts from the Maryland State Department of Education; (4) travel for consultants; (5) consultant fees; or (6) release time for teachers and related service staff.

11. List individuals or groups outside your agency who provide services to children in your geographic area who might benefit from attending the requested training. Include staff from residential and nonpublic programs as appropriate.

12. Direct all Training Request Forms to:

    Director, CSPD
    Maryland State Department of Education
    P.O. Box 8717, BWI Airport
    Baltimore, MD 21240

MSDE REVIEW PROCEDURE

Upon receipt of a Training Request Form, the Program Development and Assistance Branch will forward the following Receipt of Training Request Form. It will indicate to the requesting agency that we have in fact received the information sent to us.

Dear

As of we have received the following training request(s) from you:

We will review them and contact you in the near future.

Sincerely,

Education Specialist
Division of Special Education

cc: Regional Administrators, as appropriate

Training Request Forms will then be directed to the appropriate Regional Administrator who will provide a technical review of the form. Regional Administrators will look for such things as: 1) the provision of the LEA Director's sign off; 2) conformity with SEA priorities, 3) the development of a cost-effective procedure; and 4) the selection of appropriate content. Once a determination has been made that these four criteria have been met, the Training Request Form and the Regional Administrator's Review Form will be sent back to the Program Development and Assistance Branch of this Division, where the finalized specifics of the training plan will be determined (see page 13). A Training Plan Form will be completed and sent back to the persons requesting training with all specifics delineated in writing. By way of example, a graphic way for describing the process would look like this.

LEA Request for Training

↘

Program Development and Assistance Branch Receipt of Training Request Form

↘

Regional Administrator Review

↘

Program Development and Assistance Branch Training Plan

↘

Delivery of Training

If you wish additional information, please contact:

Dr. Camille McGreevy Peck

Maryland State Department of Education
Division of Special Education
(301) 796-8300, extension 359

Maryland State Department of Education
Division of Special Education

Comprehensive System of Personnel Development

TRAINING REQUEST FORM

1. Agency:

   Title of Inservice Training:

   Contact Person:

   Address:

   Phone No.:

   Date: _____

   _____
   Signature of the Director of Special Education
   for the Local Education Agencies
   Date: _____

2. Training Area to be addressed (please refer to the Training Areas listed in the CSPD Manual):

3. State the outcomes or objectives of the Training:

4. Service delivery method or strategy requested (one-day workshop, coursework, observation, etc.):

5. Participants (describe the number and positions of these individuals):

6. Timeframe (indicate the time period during which the training is to take place, along with specific dates, if appropriate):

7. Location of training and information regarding arrangements for training site:

8. List materials needed, if appropriate:

9. Indicate the costs which this training will involve and the source of funding, including those costs which you expect Maryland State Department of Education to cover:

10. Provide additional information if necessary:

11. List individuals or agencies outside your areas of responsibility who might reasonably participate in this training, e.g. parents, the local developmental center, student teachers assigned to your program, etc.

12. Have you contacted an appropriate institution of higher education in your geographic locale for assistance with this inservice?
YES_____ NO_____

Would you like assistance from this Division in contacting an IHE for support, delivery, credit, etc. for this training?

Return this form to: The Program Development and Assistance Branch
Division of Special Education
Maryland State Department of Education
P.O. Box 8717, BWI Airport
Baltimore, Maryland 21240

Maryland State Department of Education
Division of Special Education

Comprehensive System of Personnel Development

TRAINING PLAN FORM

Date:

Contact Person:

Content Area:

Regional Administrator's Evaluation: Approve_____ Disapprove_____

Program Development and Assistance
Branch Evaluation: Approve_____ Disapprove_____

Modification and Recommendations:

Specifics of Implementation

1. Individual(s) who will deliver training:
2. Source of funds (Attach a budget page, if appropriate):
3. Strategy:
4. Evaluation procedure:
5. Location:
6. Schedule:
7. Additional information:

_____
Signature of Director, Personnel
Development Project

PROVISION OF INSERVICE CREDIT

The participants who receive training through utilization of the above procedure are eligible to receive inservice credit through the Maryland State Department of Education, Division of Certification & Accreditation. As with all other inservice training, the procedures to be followed in requesting inservice credit must be those employed by the Division of Certification & Accreditation. A copy of the necessary forms for requesting Inservice Credit may be obtained through the Maryland State Department of Education, Division of Certification & Accreditation.

APPENDIX C

MARYLAND DIRECTION SERVICE CENTERS

The Maryland Direction Service Centers (Direction Centers), a component of the Division's child advocacy effort, are a service for handicapped persons and their families who need assistance in securing appropriate services. The needs of the handicapped are matched with available resources throughout the State. Direction Centers provide individual aid and follow-up services and assist in coordinating the resources of service agencies so that a comprehensive service plan can be implemented for the handicapped.

Direction Centers are located in Frostburg (Western Maryland) and in Upper Marlboro (Central Maryland). The Western Maryland Center serves Allegany, Garrett, Washington, and Frederick Counties. The Central Maryland Center serves Prince George's, Calvert, Charles, St. Mary's and Montgomery Counties. Counties not associated with a center should contact the Division of Special Education, Maryland State Department of Education.

The Centers, which are federally funded and operate under subcontract arrangements with the MSDE, provide services which are compatible with their respective geographical catchment areas. They are under the administration and coordination of the Central Office, located within the Division of Special Education. In addition to extensive information and referral services, Direction Center activities include participation in child-find, parent workshops, inservice training, and community outreach.

APPENDIX D

MARYLAND ARC CHAPTERS

Allegany County ARC - There is none

Anne Arundel County ARC - 937 Spa Road, Annapolis, 21401, 269-1883 or 268-8085

Baltimore City and County ARC - 4800 York Road, Baltimore 21212, 323-5600

Calvert County ARC - Star Route 1, Box 263, Prince Frederick, 20678, 535-2413

Caroline County ARC - P.O. Box 242, Ridgely, 21660, 634-2687

Carroll County ARC - 562 Baltimore Blvd., Westminster, 21157, 848-4124

Cecil County ARC - P.O. Box 477, Route 1, Perryville, 21903, 642-6728

Charles County ARC - P.O. Box 222, La Plata, 20646, 645-0700

Dorchester County-"Mid Shore ARC" (Talbot & Dorchester Counties)-302 Mill Street, Cambridge, 21613, 228,4320

Frederick County ARC - 431 Carrollton Drive, Frederick, 21701, 663 0909

Garrett County ARC - Star Route 219, P.O. Box 172, Oakland, 21550

Harford County - "Northern Maryland Society for the Aid of Retarded Children" - P.O. Box 610, Aberdeen, 21001, 836-7177 or 879-6785

Howard County ARC - Suite 251, Wilde Lake, Village Green, Columbia, 21044 730-0638

Kent County ARC - c/o Angels Haven of Kent, Betterton, 21610, 348-5886

Montgomery County ARC - 11212 Norris Drive, Silver Spring, 20902, 949-1454

Prince George's County ARC - Suite 606, 4235 28th Avenue, Marlow Heights, 20031 423-3110

Queen Anne's County ARC - 223 Broadway Avenue, Centreville, 21617, 758-0149

St. Mary's County ARC - 310 St. Andrew's Lane, California, 20619, 862-2326 or 373-8497

Talbot - same as Dorchester County's ARC

Somerset County ARC - there is none

Washington County ARC - 603 Oak Hill Avenue, Hagerstown, 21740, 797-3380

Wicomico County ARC - P.O. Box 1322, Salisbury, 21801, 883-3106

Worcester County ARC - P.O. Box 38, Newark, 21841, 632-1636

Main Body - 55 Gwynns Mill Court, Owings Mills 21117, Executive Director, Wilbor Cox

10-25-78

APPENDIX E

RESPITE CARE PROGRAMS IN THE BALTIMORE METROPOLITAN AREA

Chimes, Inc. Respite Care

Area Served: Baltimore City & Baltimore County

Eligibility: Mental retardation, ages 21 years and over, may be eligible if person is enrolled in a day educational program and can provide own transportation.

Services: Short-term overnight care in residential program, maximum length of stay 14 days.

Cost: $-0-

Contact: Social Worker for Residential Programs
Chimes, Inc.
1803 Thornbury Road
Baltimore, Maryland 21209
301-466-4400

Family Resources Program

Area Served: Baltimore City & Baltimore County

Eligibility: Mental retardation, all ages

Services: Respite care in home or in caregiver's home

Cost: Sliding scale basis

Contact: Joanna Elliott
Family Resources Coordinator
Baltimore Association for Retarded Citizens
4800 York Road
Baltimore, Maryland 21212
301-323-5600

Gallagher Center Respite Care

Area Served: Baltimore City & Baltimore County

Eligibility: Mental retardation, ages 5 years and over, must be enrolled in a day program.

Services: Short-term overnight care

Cost: Sliding scale basis

Contact: Wanda Wilson
Gallagher Center
2520 Pot Spring Road
Timonium, Maryland 21093
301-252-4005

Highland Health Facility Respite Care

Area Served: Baltimore City & Baltimore County

Eligibility: Mental retardation, up to 18 years of age

Services: Short-term overnight care

Cost: Sliding scale basis

Contact: Deloris Miller
Highland Health Facility, 3rd Floor
5200 Eastern Avenue
Baltimore, Maryland 21224
301-276-7000

Rosewood Center Respite Care

Area Served: Baltimore City & Baltimore County (also serves Carroll, Harford and Howard Counties)

Eligibility: Mental retardation, all ages

Services: Short-term overnight care; maximum 2 weeks unless circumstances warrant longer period of stay.

Cost: Sliding scale basis

Contact: Helen C. Lee
Supervisor of Admissions
Rosewood Center
Owings Mills, Maryland 21117
301-363-0300

United Cerebral Palsy of Central Maryland Respite Care Programs

"Oh What A Relief It Is"

Area Served: Baltimore City & Baltimore County*

Eligibility: All developmentally disabled, all ages

Services: In-home/out-of-home respite care

Cost: Sliding scale basis/fees dependent on ability to pay; $0-10 per day, sitter service for minimum 3 hours $4.20, or 88¢ per hour maximum cost for each additional hour.

Contact: Eleanor Baker
United Cerebral Palsy of Central Maryland
8641 Loch Raven Boulevard
Baltimore, Maryland 21204
301-668-4923

Homestyle Care

Area Served: Same as above.

Eligibility: Cerebral palsy, all ages; mental retardation, epilepsy, autism and other disabilities, 6 months and up.

Services: Temporary in-home care for emergency, weekend or vacation purposes; in-home sitting/companion services; homemaker services available to mental retardation clients.

Cost: Same as above.

Contact: Same as above.

St. Vincent's Child Care

Area Served: Same as above.

Eligibility: Cerebral palsy, 0-8 years of age, and non-ambulatory

Services: Short-term overnight care

Cost: Same as above.

Contact: Same as above.

* Also serves Anne Arundel, Howard, Washington and Frederick Counties. See Central and Western Maryland listings.

Mt. Washington Pediatric Hospital Respite Care

Area Served: Baltimore City and Baltimore County

Eligibility: Any disability; infants to 16 years of age

Services: Short-term overnight care.

Cost: Sliding scale basis

Contact: Eleanor Baker
United Cerebral Palsy of Central Maryland
8641 Loch Raven Boulevard
Baltimore, Maryland 21204
301-668-4923

RESPITE CARE PROGRAMS IN CENTRAL MARYLAND

Anne Arundel County Respite Care

Area Served: Anne Arundel County

Eligibility: All developmental disabilities and handicaps

Services: In-home/out-of-home sitting and referral

Cost: $1.50 per hour; $15.00 overnight, $90.00 per week

Contact:
Marcia Donald
Respite Care Coordinator
Anne Arundel County Association for
Retarded Citizens
937 Spa Road
Annapolis, Maryland 21401
301-269-1883

Bello Machre Respite Care

Area Served: Anne Arundel County

Eligibility: Mental retardation, all ages, and must be enrolled in an Anne Arundel County program.

Services: Short term overnight care, limited to 14 consecutive days; daytime respite for emergency situations.

Cost: $10.00 per day with a sliding scale; less than one day is free.

Contact:
Mrs. Sandra Inzina
Bello Machre
Box 969
Freetown Road
Glen Burnie, Maryland 21061
301-255-3805

Carroll County Department of Social Services Respite Care

Area Served: Carroll County

Eligibility: Mental retardation, all ages

Services: Homemaker service; in-home/out-of-home respite care

Cost: Sliding scale basis; $2.50 an hour maximum;
24 hour care: client in school $30, at home $36.
Weekly care: client in school $250, at home $300.
(less than week--fee breakdown per diem)

Contact: Frieda Cronhardt
Supervision of Homemaker Services
Carroll County Department of Social Services
95 Carroll Street
Westminster, Maryland 21157
301-848-5060
301-876-2190 (Tie Line for Baltimore)

Crippled Children's Society - Easter Seals

Home Care for the Handicapped

Area Served: Carroll County

Eligibility: All developmentally disabled, all ages

Services: Sitter/companion in-home respite services

Cost: $1.50 per hour, $12 per 12 hours, $60 per week

Contact: Mellisa Wilmer
Carroll County Office
Easter Seal Society
301-857-5475

Harford County Respite Care

Area Served: Harford County

Eligibility: Mental retardation, ages 6 years and over, must be ambulatory and participating in a day program.

Services: Non-emergency, short-term respite care in group homes.

Cost: $3-10 per day, based on ability to pay.

Contact: Col. Robert W. McEvoy
Northern Maryland Society for the Aid of Retarded Children
P. O. Box 610
Aberdeen, Maryland 21001
301-836-7177
301-879-6785 (Tie Line for Baltimore)

Henryton Center Respite Care

Area Served: Anne Arundel, Carroll, Harford and Howard Counties

Eligibility: Mental retardation, 18 years of age and over

Services: Short-term overnight care, up to 28 consecutive days within a 12-month period.

Cost: Sliding scale basis

Contact: Jean English
Henryton Center
Henryton, Maryland 21080
301-795-2400

Howard County Respite Care

Area Served: Howard County

Eligibility: Mental retardation, all ages

Services: Homemaker, in-home respite care

Cost: Sliding scale basis

Contact: Jackie Ring, Coordinator
Howard County Association for Retarded Citizens
Suite 251
Wilde Lake Village Green
Columbia, Maryland 21044
301-465-8633

Montgomery County Department of Social Services Respite Care

Area Served: Montgomery County

Eligibility: All developmentally disabled, all ages

Services: In-home/out-of-home care

Cost: $1.50 per hour, $15.00 per day; sliding scale basis

Contact: Corrine Stevens
Respite Care Coordination Unit
Montgomery Co. Department of Social Services
5630 Fishers Lane
Rockville, Maryland 20852
301-468-4356

United Cerebral Palsy o Central Maryland Respite Care Program

Hyattsville Manor Respite Care

Area Served: Anne Arundel and Howard Counties*

Eligibility: Cerebral palsy or a similar neurological condition, 16-22 years of age

Services: Short-term overnight stay

Cost: Sliding scale basis

Contact: Eleanor Baker
United Cerebral Palsy of Central Maryland
8641 Loch Raven Boulevard
Baltimore, Maryland 21204
301-668-4923

RESPITE CARE PROGRAMS ON THE EASTERN SHORE

Holly Center Respite Care

Area Served: Entire Eastern Shore (9 counties)

Eligibility: Mental retardation, all ages

Services: Short-term overnight care, up to 27 consecutive days in a 12 month period.

Cost: Sliding scale basis

Contact: Adelaide Haines
Holly Center
P.O. Box 2358
Snow Hill Road
Salisbury, Maryland 21801
301-546-2181

Eastern Shore Homemaker Services

Area Served: Entire Eastern Shore (9 counties)

Eligibility: Mental retardation, all ages; autistic, and all developmental disabilities.

Services: Homemaker services/respite home placement; long-term relief.

Cost: Sliding scale basis

Contact: Cecil & Kent Counties - Robert Gilgrist
398-5108

Caroline & Queen Anne Counties - Pat Schwaninger
546-2181

Dorchester & Talbot Counties - Don Ford
822-4122

Wicomico & Worcester Counties - Ernestine Upshur
546-2181

Somerset County - Linda Anderson
651-0822 or 651-0823

Director of Community Services - Bill Snavely
546-2181

The Mid-Shore Respite-Relief Care Programs

Area Served: Caroline, Dorchester, Kent, Queen Anne, Talbot Counties

Eligibility: All developmentally disabled, all ages

Services: Short-term care services, in-home or out-of-home; homemaker services up to 1 month; respite care up to 3 weeks in-home.

Cost: Sliding scale basis; $1.50 per hour for first 2 hours, $1.00 per hour afterwards, $12.00 per night.

Contact: Thomas J. Barckley
Respite Coordinator
300 Shephard Avenue
Cambridge, Maryland 21613
301-376-3262

Santo A. Grande
Administrative Director
Dorchester Developmental Unit, Inc.
P. O. Box 592
Cambridge, Maryland 21613
301-228-9274

RESPITE CARE PROGRAMS IN SOUTHERN MARYLAND

Great Oaks Center Respite Care

Area Served: Calvert, Charles, Prince Georges, Montgomery and St. Mary's Counties

Eligibility: Mental retardation, all ages

Services: Short-term overnight care

Cost: Sliding scale basis

Contact: Paul Wang
Great Oaks Center
12001 Cherry Hill Road
Silver Spring, Maryland 20904
301-595-5062

Prince Georges County Department of Social Services

Area Served: Prince Georges County

Eligibility: All disabilities, all ages

Services: In-home/out-of-home respite care; day care

Cost: To be determined; subsidy available

Contact: Mrs. June Campbell
Prince Georges County Department of Social Services
301-927-4600, Ext. 204

Helping Hands for the Handicapped - Charles County Respite Services

Area Served: Charles County

Eligibility: Any handicapped individual, all ages

Services: long and short-term in-home/out-of-home care; day care facilities available; overnight care.

Cost: To be determined by caregiver.

Contact: Respite Care Coordinator
Charles County Association for Handicapped and Retarded Citizens
P.O. Box 222
La Plata, Maryland 20646
301-645-9250, or 645-9251

PROPOSED RESPITE CARE SERVICES IN SOUTHERN MARYLAND

St. Mary's County Department of Social Services Respite Care

Area Served: St. Mary's County

Eligibility: All developmentally disabled, all ages

Services: In-home respite care/out-of-home day care; in-home overnight care.

Cost: $2.00 per hour, $18 per day.

Contact:
Ms. Liesl Stark
Respite Care Coordinator
St. Mary's County Department of Social Services
P. O. Box 317
Leonardtown, Maryland 20650
301-475-2821

RESPITE CARE PROGRAMS IN WESTERN MARYLAND

Crippled Children's Society - Easter Seals

Home Care Services for the Handicapped

Area Served: Frederick and Washington Counties*

Eligibility: All developmentally disabled, all ages

Services: Sitter/Companion service, in-home respite services (out-of-home care planned for near future).

Cost: $1.50 per hour, $12 per 12 hours, $60 per week

Contact: Katherine Higgins
Home Care Coordinator
Easter Seal Society
901 Dewey Avenue
Hagerstown, Maryland 21740
301-797-4500 (in Washington County)
301-293-2818 (in Frederick County)

Home Care Services for the Handicapped

Area Served: Allegany and Garrett Counties

Eligibility: Mental retardation, all ages

Services: In-home respite care; homemaker services; full client services with follow-up for disabled individuals.

Cost: Same as above.

Contact: Mary K. August
Director of Client Services
Western Maryland Directions Center
Frostburg State College
Frostburg, Maryland 21532
301-689-8879

* Also serves Carroll County; see Central Maryland listings.

United Cerebral Palsy of Central Maryland Respite Care Program

Colton Manor Respite Care

Area Served: Washington and Frederick Counties*

Eligibility: Cerebral palsy and similar neurological conditions, ages 16-22 years.

Services: Temporary placement for emergency, weekend, or vacation purposes.

Cost: Sliding scale basis/fees dependent on ability to pay; $0-10 per day, sitter service for minimum 3 hours $4.20, or 88¢ per hour maximum cost for each additional hour.

Contact: Eleanor Baker
United Cerebral Palsy of Central Maryland
8641 Loch Raven Boulevard
Baltimore, Maryland 21204
301-668-4923

Victor Cullen Center Respite Care

Area Served: Allegany, Frederick, Garrett and Washington Counties

Eligibility: Severely and profoundly mentally retarded; over 18 years of age; must be ambulatory with no major medical problems or behavior problems.

Services: Short-term overnight care (2 beds available: 1 male, 1 female)

Cost: Sliding scale basis.

Contact: Jim Spielman
Respite Care Coordinator
Western Maryland Office
Mental Retardation Administration
1380 Marshall Street
Hagerstown, Maryland 21740
301-791-4655

* Open to all Maryland residents.

Western Maryland I Mental Retardation Center - Hagerstown

Area Served: Washington and Frederick Counties

Eligibility: Mentally retarded, all ages, ambulatory or non-ambulatory with no major medical problems or severe behavior problems.

Services: Short-term overnight care, weekends, or up to 28 consecutive days in a 12 month period. (6 beds)

Cost: Sliding scale basis.

Contact: Jim Spielman
Respite Care Coordinator
Western Maryland Office
Mental Retardation Administration
1380 Marshall Street
Hagerstown, Maryland 21740
301-791-4655

Western Maryland II Mental Retardation Center - Cumberland

Area Served: Allegany and Garrett Counties

Eligibility: Mentally retarded, ambulatory or non-ambulatory with no major medical problems or severe behavior problems.

Services: Short-term overnight care, weekends, or up to 28 consecutive days in a 12 month period. (2 beds)

Cost: Sliding scale basis.

Contact: Jim Spielman
Respite Care Coordinator
Western Maryland Office
Mental Retardation Administration
1380 Marshall Street
Hagerstown, Maryland 21740
301-791-4655

APPENDIX F

THE DEAF/BLIND PROJECT

The Maryland Deaf/Blind Project is a program of the Division of Special Education, funded under P.L. 91-230, Title VI-C. Its purpose is to provide direct educational and diagnostic services to children birth through 21 who have significant vision and hearing impairments in combination. Other components of the project include family counseling and home training, inservice training for parents and for personnel engaged in services for deaf/blind children, a lending library of special reading and teaching materials relevant to the deaf/blind child, dissemination of information, and maintenance of a central registry.

Deaf/blind programs are currently operated at the Maryland School for the Blind, Rosewood, Great Oaks, and Holly Centers, and the United Cerebral Palsy Association of Prince George's County, Inc.

APPENDIX H

SURROGATE PARENT GUIDELINES

The Maryland State Department of Education, in conformity with P.L. 94-142, has developed guidelines concerning the use of parent surrogates when necessary as educational decision makers. This document, referred to as "Surrogate Parent Guidelines," is available from the Division of Special Education.

APPENDIX I

MARYLAND STATE DEPARTMENT OF EDUCATION PUBLICATIONS

1. Maryland's Comprehensive System of Personnel Development: The Manual for Training.
2. The Protection-In-Evaluation Manual.
3. The Direction Centers' Directory.
4. The Legal Rights Handbook.
5. Transportation of Handicapped Children.